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Hearings. v. 60-62, 1962

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# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

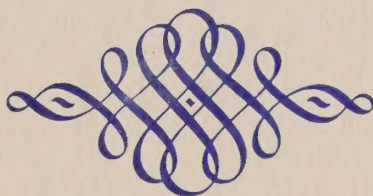
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ROYAL COMMISSION ON THE SERVICE OF THE CANADIAN PHARMACEUTICAL INDUSTRY

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 25th day of May, 1962.

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COMMISSION MEMBERS:

CANADIAN HARBOUR CONGRESS

TORONTO AND DISTRICT EX-SERVICEMEN'S

ADVISORY COMMITTEE

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THE CANADIAN CONFERENCE OF

PHARMACEUTICAL FACULTIES

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COMMISSION SECRETARY:

MR. N. LAFRANCE





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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 25th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALE --- Chairman

MISS ALICE GIRARD, R.N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON - Acting Chairman

PROF. O. J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE





Division of the Department of  
the Interior, Bureau of  
Land Management, Denver, Colorado

Washington, D. C.

February 1, 1934

Very respectfully,  
Sincerely,  
Very truly yours,

W. E. Hail, Jr.

Chief of Bureau

Department of the Interior

Mr. W. E. Hail, Jr.

Chief of Bureau

Department of the Interior

W. E. Hail, Jr.

W. E. Hail, Jr.

W. E. Hail, Jr.

Chief of Bureau

W. E. Hail, Jr.

Chief of Bureau

W. E. Hail, Jr.

Mr. W. E. Hail, Jr.



1  
2  
3 ---On resuming at 9:30 a.m.

4  
5 THE SECRETARY: Mr. Chairman, the  
6 first brief this morning is that of the Canadian Labour  
7 Congress, which will be known as exhibit number 319,  
8 and Mr. Jodoin will introduce his group and read his  
9 statement.

10 ---EXHIBIT NO. 319: Submission of the  
11 Canadian Labour Congress.

12 SUBMISSION OF  
13 THE CANADIAN LABOUR CONGRESS

14 APPEARANCES:

15 Claude Jodoin  
16 Donald MacDonald  
17 A. Andras  
18 T. Goldberg  
19 Dr. E.A. Forsey.

20 MR. JODOIN: Your Honour, Mr. Chairman,  
21 if I might introduce Mr. Donald MacDonald, Secretary-  
22 Treasurer of our Congress, Mr. Andras, Director of our  
23 Legislative Committee, I don't know whether he is  
24 campaigning now or not. Mr. Goldberg of the Research  
25 Department of one of our affiliates, the United  
26 Steelworkers of America.

27 Mr. Chairman and Members of the Royal  
28 Commission:

29 The brief submitted by the Canadian  
30 Labour Congress has been in your hands for some time.  
We assume that it has received your careful considera-  
tion. We realize that our brief is one of a very large  
number of representations made to you and we appreciate





THE SPEAKER: Mr. Chairman, the

first brief this morning is that of the Canadian Labour  
Congress, which will be known as exhibit number 11,  
and Mr. Jodoin will introduce his group and read his  
statement.

---EXHIBIT NO. 11

Submission of the  
Canadian Labour Congress

COMMITTEE ON

THE CANADIAN LABOUR CONGRESS

A. Jodoin  
T. Jodoin

MR. JODOIN: Your Honour, Mr. Chairman,

it is right to introduce Mr. Donald MacDonald, Secretary-  
Treasurer of our Congress, Mr. Andrew, Minister of our  
Parliamentary Committee, I don't know whether he is  
campaigning now or not. Mr. Goldstein of the Research  
Department of one of our affiliated, the United  
Steel Workers of America.

Mr. Chairman and members of the Royal

Commission.

The brief submitted by the Canadian

Labour Congress has been in your hands for some time.  
We assume that it has received your careful considera-  
tion. We realize that our brief is one of a very large  
number of representations made to you and we appreciate

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4 this opportunity of appearing before you.

5 Our position, briefly stated, is that  
6 the most effective way of providing for the health care  
7 of the Canadian people is through a public health care  
8 program rather than through the extension of existing  
9 private plans. We have suggested to you that such a  
10 public program should provide a comprehensive range of  
11 health care services to all who need them, in whatever  
12 form they need them and to the extent that they need  
13 them, without any economic obstacle between people and  
14 services. We have urged a program that would provide  
15 care of the highest quality and have argued that such  
16 quality depends not only on the technical competence of  
17 the medical practitioner but on the way in which the care  
18 itself is organized, that is, the effective co-ordination  
19 of personnel and resources. In our brief, we have  
20 dealt with these and related matters in some detail  
21 and we do not consider it necessary to do so extensively  
22 here. The essentials of a public health care program,  
23 as we see them, are universality of coverage,  
24 comprehensiveness in range of services, a high order of  
25 quality of services, the absence of any financial  
26 deterrents against the use of health care services  
27 and the equitable financing of the program as a whole.

28 There are some further comments we wish  
29 to make to supplement what we have already said in our  
30 brief. We refer in particular to the question of  
voluntarism and to the role of the private plans. It  
is well known to you that the success which the private  
plans have enjoyed is due in large measure to the





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1 This opportunity of appearing before you,  
2 for discussion, is gratefully acknowledged, is that  
3 a most effective way of providing for the health care  
4 of the American people is through a health care  
5 program rather than through the extension of existing  
6 private plans. We have suggested to you that such a  
7 public program should provide a comprehensive range of  
8 health care services to all who need them, in whatever  
9 form they need them and to the extent that they need  
10 them, without any economic barriers between people and  
11 services. We have urged a program that would provide  
12 care of the highest quality and have argued that such  
13 quality depends not only on the technical competence of  
14 the medical profession but on the way in which the care  
15 itself is organized, that is, the effective co-ordination  
16 of personnel and resources. In our brief, we have  
17 dealt with these and related matters in some detail  
18 and we have suggested that you should consider them  
19 in detail. The essentials of a public health care program,  
20 as we see them, are universality of coverage,  
21 comprehensive in range of services, a high order of  
22 quality of services, the absence of any financial  
23 barriers against the use of health care services,  
24 and the effective financing of the program as a whole.  
25 There are some further comments we wish  
26 to make to supplement what we have already said in our  
27 brief. We refer in particular to the location of  
28 volunteer and to the role of the private plans. It  
29 is well known to you that the degree with which the private  
30 plans have enjoyed in the past access to the



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4 collective bargaining efforts of the trade unions  
5 themselves. During and after the last war, trade unions  
6 made it a part of their collective bargaining demands  
7 to ask for inclusion of protection for the worker and  
8 his family against the hazards of illness and accident  
9 in the conditions of employment (as well as other average  
10 contingencies such as death and dismemberment, and loss  
11 of income due to illness). In some instances, such  
12 protection was obtained through coverage under the  
13 non-profit plans sponsored by the medical profession,  
14 in others through the insurance industry, while to a more  
15 limited extent coverage was also obtained through  
16 co-operative associations. Regardless of the type of  
17 coverage, however, the fact remains that a very large  
18 measure of success on the part of any of these agencies  
19 was due to the concentration of the unions on these  
20 so-called fringe benefits. We are accordingly familiar  
21 with these plans and know their advantages as well as  
22 their limitations.

23  
24 You will notice, Mr. Chairman, that  
25 there was some shuffling here between Director Andras  
26 and myself. It was because I didn't have the last copy  
27 of our representation here at this moment, which you  
28 have, Your Honour, and your colleagues also, so there  
29 was some differences in certain paragraphs. I beg of  
30 you not to hold it against us sir.

These plans have been urged upon you  
as the vehicles through which coverage should be extended,  
on the grounds that this would avoid the element of  
compulsion in coverage. We have no intention of venturing





collective bargaining as a means of securing the interests of the workers and their families. During and after the last war, trade unions were at a point of their collective bargaining campaign to ask for inclusion of protection for the worker and his family against the hazards of illness and accident in the conditions of employment (as well as other contingencies such as death and disablement, and loss of income due to illness). In some instances, such protection was obtained through coverage under the non-profit plans sponsored by the medical profession, in others through the insurance industry, while in a more limited extent coverage was also obtained through co-operative associations. Regardless of the type of coverage, however, the fact remains that a very large measure of success on the part of any of these agencies was due to the concentration of the unions on these so-called fringe benefits. We are accordingly familiar with these plans and know their advantages as well as

You will notice, Mr. Chairman, that there was some shifting here between Winston and the witness. It was because I didn't have the last copy of the representation here at this moment, which you see, John Brown, and your colleagues also, so there was some shifting in the representation. I feel we had not to hold it against us.

These plans have been under your eye as the witness through this coverage and it is entirely in the interest of the worker to avoid the element of competition in coverage. We have no intention of venturing



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3 into a philosophic discussion of freedom. We would  
4 merely point out that no organized society recognizes  
5 absolute freedom. Insofar as the private plans are  
6 concerned, the notion that they make possible voluntary  
7 choice is to a very considerable extent a fiction. Such  
8 plans exist largely on their ability to provide coverage  
9 on a group basis and they offer to groups economies  
10 which are not possible in the case of individual contracts.  
11 In the arena of collective bargaining, agreement is  
12 reached between the union and the employer not only  
13 on the type of benefits to be provided, but on their cost,  
14 selection of the underwriter and the extent to which the  
15 employer will cover all or part of the cost. Once  
16 such an agreement is made, a plan is introduced for the  
17 whole group and the exercise of choice by the individual  
18 employees is virtually eliminated. In cases where the  
19 employer pays 100 per cent of the cost of the plan,  
20 coverage is automatically universal and the element of  
21 voluntarism is to all intents and purposes non-existent.  
22 In effect, therefore, when a union and an employer  
23 have reached an agreement and that agreement has been  
24 approved by the union through a majority voting in its  
25 favour, that plan is established for the group as a whole  
26 and it would be unusual for any employee to refrain from  
27 accepting its benefits on the grounds that his  
28 inclusion is an invasion of his freedom. To champion the  
29 private plans, therefore, on the grounds of voluntarism  
30 is to engage in the merest sophistry.

It is our very experience with the  
private plans that has forced us to the conclusion that

into a philosophic discussion of freedom. We would merely point out that no organized society recognizes absolute freedom. Insofar as the private plans are concerned, the notion that they have possible voluntary choice is to a very considerable extent a fiction. Such plans exist largely on their ability to provide coverage on a group basis and they offer to groups economies which are not possible in the case of individual contracts. In the arena of collective bargaining, agreement is reached between the union and the employer not only on the type of benefits to be provided, but on their cost, selection of the underwriter and the extent to which the employer will cover all or part of the cost. Once such an agreement is made, a plan is introduced for the whole group and the exercise of choice by the individual employee is virtually eliminated. In cases where the employer pays 100 per cent of the cost of the plan coverage is automatically universal and the element of voluntarism is to all intents and purposes non-existent. In effect, therefore, when a union and an employer have reached an agreement and that agreement has been approved by the union through a majority vote in its favour, that plan is established for the group as a whole and it would be unusual for any employee to refrain from accepting its benefits on the grounds that his inclusion is an invasion of his freedom. To question the private plans, therefore, on the grounds of voluntarism is to engage in the nearest approximity.

It is our very experience with the private plans that has forced us to the conclusion that





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4 they cannot be counted upon to fulfil the task of pro-  
5 viding the Canadian people with the health care that  
6 they require. Even at their best, and some are obviously  
7 better than others, they fall short of taking care of  
8 the health needs of those covered by them. This  
9 deficiency is particularly true of the plans provided  
10 by the commercial carriers but it is true also of the  
11 non-profit plans sponsored by the medical profession.  
12 Accordingly, the extension of these plans to cover the  
13 whole population would not meet the objective of  
14 giving to the Canadian people all the health care that  
15 they require. This has been our experience and we  
16 have elaborated on this point to some extent in our  
17 brief. We wish to emphasize it here because of the  
18 very considerable effort on the part of others to give  
19 the private plans a more commanding role in the field  
20 of health care than they have at present.

21  
22 There is one further point, once again  
23 related to the private plans and to the supporting  
24 arguments in their favour. We refer to the proposal  
25 that a means test be applied in the matter of premium  
26 payments to these plans in the case of those who are  
27 unable to pay such premiums otherwise. We wish to  
28 state in unequivocal terms that we are opposed to the  
29 large-scale extension of the means test principle.  
30 Such a test should be merely peripheral to the main  
body of social security legislation. We strongly oppose  
its extension on a large scale so that a very substantial  
proportion of the population would have to submit to it.  
It is an unpalatable procedure, both to those who apply



they cannot be counted upon to fulfill the task of providing the Canadian people with the health care that they require. Even at their best, and some are obviously better than others, they fall short of taking care of the health needs of those covered by them. This deficiency is particularly true of the plans provided by the commercial carriers but it is true also of the non-profit plans sponsored by the medical profession. Accordingly, the extension of these plans to cover the whole population would not meet the objective of giving to the Canadian people all the health care that they require. This has been our experience and we have elaborated on this point to some extent in our brief. We wish to emphasize it here because of the very considerable effort on the part of others to give the private plans a more commanding role in the field of health care than they have at present.

There is one further point, one which refers to the private plans and to the endorsement of them in their favour. We refer to the proposal that a means test be applied in the matter of premium payments to these plans in the case of those who are unable to pay such premiums otherwise. We wish to state in unambiguous terms that we are opposed to the introduction of this extension of the means test principle. Such a test should be merely ancillary to the administration of social security legislation. We strongly oppose its extension on a large scale so that a very substantial proportion of the population would have to submit to it. It is an undesirable procedure, both to those who apply



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4 it and to those who must fulfil its requirements. It  
5 carries with it a social stigma. It is difficult and  
6 costly to administer. The distaste with which the means  
7 test is regarded may cause many self-respecting citizens  
8 to refrain from getting the health care they require if  
9 the price of getting it is through a means test. For  
10 all these reasons, we have suggested that the public  
11 health care program which we advocate should be financed  
12 as much as possible in a way which will minimize rather  
13 than expand the requirement to apply any test other than  
14 the need for the service itself.

15 We have taken advantage of our  
16 opportunity to make a preliminary statement to stress  
17 these points rather than to summarize the contents of  
18 our brief. We have done so in view of the importance of  
19 these matters and hope that they will receive your  
20 serious consideration.

21 It is respectfully submitted to you,  
22 Your Honour, and the Members of the Commission, and  
23 duly signed by the officers of the Congress.

24 THE CHAIRMAN: Thank you very much  
25 Mr. Jodoin. Your procedure in reading a statement  
26 rather than summarizing is quite acceptable, and as a  
27 matter of fact opens up the subject to a discussion in  
28 a better way than merely the reading of a longer brief,  
29 and we are looking forward to some discussion with you  
30 this morning on the whole topic of health services  
which is before us, and which includes much more of  
course than physicians' services.

I am going to ask Dr. Firestone if he





it is to those who must fulfill its requirements. It  
carries with it a social stigma. It is difficult and  
costly to administer. The data with which the means  
test is regarded may cause many self-respecting citizens  
to refrain from getting the health care they require if  
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We have taken advantage of our  
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these matters and hope that they will receive your  
attention.

It is respectfully submitted to you,  
Your Honor, and the Members of the Commission, and  
truly signed by the officers of the Congress.

THE CHAIRMAN: Thank you very much.

Mr. Tolson. Your procedure in reading a statement  
rather than summarizing is quite acceptable, and as a  
matter of fact opens up the subject to a discussion in  
a better way than merely the reading of a longer brief,  
and we are looking forward to some discussion with you  
this morning on the whole topic of health services  
which is before us, and which involves much more than

I am going to ask Mr. Tolson to ask



Jodoin

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will undertake to open the discussion.

COMMISSIONER FIRESTONE: Mr. Chairman, Mr. Jodoin, in asking some questions of you, please feel free to call upon your associates to answer particular questions.

MR. JODOIN: Thank you very much Doctor. I assure you I will use the privilege with your permission.

COMMISSIONER FIRESTONE: The Canadian Labour Congress in putting its proposal for a comprehensive medical care program before this Commission, speaks of a program that should be universally available, without regard for means, and it should seek to provide health care of the highest quality, and I am referring to your paragraphs 7 and 8 on page 6 of your brief.

The point has been made to this Commission that this objective is rather difficult to achieve if one were to embark on a comprehensive program which is compulsory, compulsory both for those that are covered and compulsory for those that are providing health services.

I am just wondering whether you or your associates have any views on this particular subject?

MR. JODOIN: Well, first of all in general terms, setting aside the moral issues, Doctor, realizing that save your soul, the most important matter for human beings these days is certainly health, there is no question about that, and thus we say that everybody, without any exception, should be covered by it, and



will undertake to open the discussion.

Mr. JORDAN, in asking some questions of you, please  
feel free to call upon your associates to answer.

MR. JORDAN: Thank you very much.  
Doctor, I assume you will use the principles with

Labour Congress in outlining its proposal for a corporate

speaks of a program that should be universally available,  
without regard for terms, and it should seek to provide  
health care of the highest quality, and I am referring  
to your paragraphs 7 and 8 on page 6 of your list.

The point has been made to this

Commission that this objective is rather difficult to  
achieve if one were to embark on a comprehensive program  
which is compulsory, compulsory both for those that  
are covered and compulsory for those that are providing  
health services.

I am just wondering whether you or

your associates have any views on this particular

subject?

MR. JORDAN: Well, first of all, in

general terms, setting aside the moral issues, Doctor,  
realizing that save your soul, the most important matter  
on human beings there is a certain health, there  
is no question about that, and if we say that every-  
body, within a reasonable expectation, should be covered by it, and





Jodoin

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2  
3 have that opportunity of the necessary medical care of  
4 course.

5 Now, to us it seems, as far as again  
6 that human being is concerned, that it is the most  
7 important matter in this world, again save the saving  
8 of your soul, if I may express myself correctly, so that  
9 is the main idea for it, and whether you are covered  
10 or not, I presume that those who would not be would for  
11 reasons of being able to take care of themselves, more  
12 or less, but there are no exceptions of course and  
13 everyone is entitled as far as we are concerned to that  
14 care.

15 Maybe my colleagues would have some  
16 details to explain in a comprehensive way how it would  
17 function, but on general terms that is my answer to  
18 you sir.

19 MR. ANDRAS: Mr. Chairman ---

20 THE CHAIRMAN: Just remain seated.

21 MR. ANDRAS: I am more accustomed  
22 to standing in the prisoner's box.

23 THE CHAIRMAN: I am afraid you are  
24 in the wrong place. We don't mind you feeling at home,  
25 but I mean to say ---

26 MR. ANDRAS: I didn't anticipate this  
27 high order of repartee, Mr. Chairman. I think I will  
28 stick to the business at hand in future, for my own  
29 protection.

30 My comments to Dr. Firestone would be  
that our program, if I remember it correctly, or our  
brief if I remember it correctly, does not engage in



Today

have that opportunity of the necessary mental care of

Now, to us it seems, as far as again

that human being is concerned, that it is the most

important matter in this world, again save the saving

of your soul, if I may express myself correctly, so that

is the main idea for it, and whether you are covered

or not, I presume that those who would not be would for

reasons of being able to take care of themselves, more

or less, but there are no exceptions of course and

everyone is entitled as far as we are concerned to that

Maybe my colleagues would have some

details to explain in a comprehensive way how it would

function, but on general terms that is my answer to

you sir.

MR. ANKLA : Mr. Chairman --

THE CHAIRMAN : Just remain seated.

MR. ANKLA : I am now associated

to standing in the prisoner's box.

THE CHAIRMAN : I am afraid you are

in the wrong place. We don't mind you feeling at home,

but I mean to say --

MR. ANKLA : I didn't anticipate this

high order of repairs, Mr. Chairman. I think I will

stick to the business at hand in future, for my own

protection.

My comments to Mr. Fiestone would be

that our program, if I remember it correctly, or can

brief if I remember it correctly, does not ensure in



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4 such words as compulsion. "We have not used it." We  
5 didn't consider it an essential term to use, although we  
6 are not shy of the word. "The fact of the matter is that  
7 if a program is universally available, then you make  
8 unnecessary reference toward the application of compulsion.

9 What we are seeking is a program of  
10 health care that everyone in Canada should be able to  
11 have access to. We have suggested that there should be  
12 no artificial bars to such accessibility. This is our  
13 point. You raised our ~~fourth~~ point, which is identified  
14 as paragraph (8):

15 "It should seek to provide health care  
16 "of the highest quality".

17 We have aduced reasons in our brief that in our opinion  
18 suggest that the only way to provide health care of the  
19 highest quality is through a public health care program,  
20 universal in its application, and so organized as to  
21 provide optimum care to all.

22 -

23 -





such words as "essential", we have not used it, we  
 didn't consider it an essential term to use, and we  
 are not shy of the word. The fact of the matter is that  
 if a program is universally available, then you make  
 unnecessary reference toward the application of legislation.

What we are seeking is a program of  
 health care that everyone in Canada should be able to  
 have access to. We have suggested that there should be  
 no artificial bars to such accessibility. This is our  
 point. You raised our fourth point, which is identified

at paragraph (2):

"It should seek to provide health care  
 "of the highest quality".

We have asked persons in our brief that in our opinion  
 suggest that the only way to provide health care of the  
 highest quality is through a public health care program,  
 universal in its application, and so organized as to  
 provide continuing care to all.

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Andras

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3 are 21 on 31 of COMMISSIONER McCUTCHEON: Is there no  
4 compulsion involved on the providers of the care, Mr.  
5 Andras? I know you shrink from the word, I know you  
6 don't like it. There are Acts of Parliament which set  
7 the rights of certain individuals.

8 allowed to do so. MR. ANDRAS: We stated that we recog-  
9 nize the fact that in an organized society there are  
10 no absolute freedoms, which means there are compulsions  
11 either of a positive or negative kind.

12 COMMISSIONER McCUTCHEON: What you are  
13 recommending is compulsion on the providers of health  
14 services to have it in the way you recommend?

15 MR. ANDRAS: No, we don't state that  
16 in our brief. We would assume that a program made  
17 universally available would in itself involve the  
18 great majority of doctors, just as it does elsewhere.

19 COMMISSIONER FIRESTONE: Perhaps if  
20 we can continue on the general line. Would you  
21 visualize a program, sir, where doctors would be  
22 permitted to practise outside such a universal plan  
23 as you recommend?

24 MR. ANDRAS: Yes. I think there  
25 would only be a marginal number of doctors, and we  
26 are not apprehensive about that.

27 COMMISSIONER FIRESTONE: And you would  
28 expect that the majority would be willing to operate  
29 under the plan but you would not necessarily make it  
30 compulsory for everybody to work under the plan?

MR. ANDRAS: No. Our feeling is that  
probably there would be 95%, in any event, and if there



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...in the...  
...involved on the grounds of the...  
...I know you think from the word, I know you  
...don't like it. There are lots of people who...  
...the right of certain individuals.  
...MR. ALBANY: We agreed that we...  
...the fact that in an organized society there are  
...no absolute freedom, which means there are...  
...either of a positive or negative kind.  
...CONSTITUTIONAL HISTORY: What you are  
...recommending is... on the grounds of...  
...advises to have it in the way you...  
...MR. ALBANY: No, we don't state that  
...in our... We would assume that a... made  
...universally available would in itself involve the  
...majority of doctors, just as it does elsewhere.  
...we can continue on the general line. Would you  
...visualize a program, sir, where doctors would be  
...permitted to practice outside such a universal plan  
...as you recommend?  
...MR. ALBANY: Yes, I think there  
...would only be a minimal number of doctors, and we  
...are not apprehensive about that.  
...CONSTITUTIONAL HISTORY: And you would  
...expect that the majority would be willing to operate  
...within the plan but you would not necessarily make it  
...mandatory for everybody to work under the plan?  
...MR. ALBANY: No, my feeling is that  
...nobody would be... in any event, and if there





Andras

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are 2% or 3% of doctors that wouldn't - it is not essential they should be.

COMMISSIONER McCUTCHEON: You visualize the situation that exists in the United Kingdom where the doctors are on the dole because they are not allowed to go into certain areas and practise?

MR. ANDRAS: I was not aware of any doctors being on the dole. This is a new form of statement to me, and I think I would have to investigate it before I would agree with it.

COMMISSIONER McCUTCHEON: I think you should investigate it.

MR. JODOIN: We don't agree with anybody being on the dole, not only the professions, but every human being.

COMMISSIONER FIRESTONE: In other words, you are visualizing, if I understand your proposal correctly, a plan that would be made available to everybody in Canada to which people would pay according to their ability to pay. But if somebody who is well off wishes to engage a doctor and pay him extra, this would be possible under the plan as you visualize it?

MR. ANDRAS: There would probably be a very small proportion of the population in such circumstances.

COMMISSIONER FIRESTONE: I am more involved with the principles which seem to be in the plan as you visualize it.

MR. ANDRAS: Our principle essentially is that 100% of the population should have available to



are 3 or 3 1/2 doctors that would be - it is not  
essential they should be.

the situation that exists in the United Kingdom where  
the doctors are on the whole because they are not  
allowed to go into certain areas and practices?

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MR. WATKINS: Our authorities are really

is that a lot of the population should have insurance to



Andras

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3 them the medical care that they require without any  
4 financial obstacle.

5 COMMISSIONER FIRESTONE: Having said  
6 that, we are now going to the next stage to see how  
7 availability would work in practice, and what we are  
8 trying to ascertain is how this might operate. You  
9 appreciate that we are talking here of a medical care  
10 plan for a country which is federally constituted,  
11 and there may be provincial variations of the plan.  
12 I presume, from what you are saying in another section,  
13 that you could visualize such a comprehensive, you may  
14 call it a national, program, with some regional varia-  
15 tions.

16 MR. ANDRAS: We envisaged a plan or  
17 suggested in Canada under our constitutional circum-  
18 stances a federal statute would probably take the form  
19 of a grants-in-aid program. We would assume that a  
20 grants-in-aid program would be conditional under a  
21 certain set of factors. It would be possible by any  
22 type of legislation for any province to deal with the  
23 standards set by any grants-in-aid program, but it  
24 would, I think, also be that such a program would  
25 require a minimum set of standards, and to the extent  
26 that the provinces would co-operate, those standards  
27 would be common.

28 THE CHAIRMAN: Before we get into  
29 this detail, as we leave the question of the general  
30 principle, you say that there should be, in some way  
or other, a program which would be universally available  
to all. That necessarily involves an obligation on







Andras

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somebody else's part to provide the services which would be available to all, would it not?

MR. ANDRAS: There would have to be the personnel to provide services, quite so.

THE CHAIRMAN: The organization?

MR. ANDRAS: Yes.

THE CHAIRMAN: These things don't ordinarily come haphazardly; they come from programming or some form of human endeavour. Would you accept that, that once you ask for a plan that is universally available there is an obligation somewhere to provide the services, on government I mean, an obligation on the authority to provide the services?

MR. ANDRAS: That is right.

COMMISSIONER FIRESTONE: As I understand, you would visualize federal legislation which would set up the provision of such a program, setting certain standards that any participating province would have to adhere to, with the Federal Government then making a contribution through the grants-in-aid system, through a provincially-operated and provincially-administered and partially provincially-financed program? Is that substantially correct?

MR. ANDRAS: That is substantially correct, yes.

COMMISSIONER FIRESTONE: In other words, to follow somewhat similar principles which are now embodied in the hospital insurance program?

MR. ANDRAS: Yes.

COMMISSIONER FIRESTONE: Now, sir, to



...the effect of the ...

...would be available to all, would it not?

MR. ANTHONY: There would have to be

the personnel to provide services, quite so.

MR. ANTHONY: Yes.

THE CHAIRMAN: These things don't

ordinarily come immediately; they come in a program

of the form of human resources, don't they?

Chairman: Once you get for a plan that is universal,

availing there is an obligation somewhere to provide

the services, on government's part, an obligation on

the authority to provide the services?

MR. ANTHONY: That is right.

CHAIRMAN: I think so. As I understand

stand, you would violate Federal legislation which

would set up the provision of such a program, setting

certain standards that any participating province

would have to adhere to, with the Federal Government

then making a contribution through the central-in-aid

system, through a provincially-created and provincially-

administered and partially provincially-financed program?

Is that substantially correct?

MR. ANTHONY: That is substantial in

concept, yes.

...to follow current similar policies which are

...in the hospital insurance program?

CHAIRMAN: I understand that, sir, to





Andras

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allow a certain flexibility in Canada, some provinces may wish to follow one way and other provinces may wish to follow another way, and we see certain variations in the application of the hospital insurance plan in Canada. Would you permit, under the program which you visualize, such regional variations which have developed in the hospital insurance program?

MR. ANDRAS: It is a question of degree, Dr. Firestone. We would want to see certain minimum services, the medical services, the nursing services, certain diagnostic services. Now, over and above ---

THE CHAIRMAN: Given those certain minimum - I think that is the way Dr. Firestone has put it.

COMMISSIONER FIRESTONE: Given the coverage of the program, accepting the minimum coverage of the program, there may be different ways in which the program may be implemented. In one province, like Ontario, if there was the same system which presently exists in the hospital insurance plan, it would be a question of compulsory contribution and voluntary contribution.

COMMISSIONER McCUTCHEON: And sales tax.

COMMISSIONER FIRESTONE: And sales tax. And in another province it may cover everybody and the provincial contribution may be collected through a provincial tax and another premium.

MR. ANDRAS: We anticipated that. In



allow a certain flexibility in Canada, some provinces

may wish to follow one way and other provinces may wish to follow another way, and we see certain variations

in the application of the hospital insurance plan in Canada. Would you permit, under the program which you visualize, such regional variations which have developed in the hospital insurance program?

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THE CHAIRMAN: Given those certain

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COMMISSIONER FINESTONE: Given the

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COMMISSIONER FINESTONE: And when

contribution was made, the government would have to provide it and cover any gap, and the hospital contribution may be collected through a provincial tax and another premium.

MR. ABRAMS: We anticipated that



Andras

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our brief we took the position that preferably we would like to see the method of financing that would eliminate the need for an earmarked tax or premium, because to the extent that this exists it takes on a progressive character and results inevitably with some people on the imposition of a means test. If we were writing the legislation and administering the program, we would do it otherwise.

But under the provincial hospital schemes there are about half-a-dozen ways of doing it: there is a sales tax, premium type of payments.

THE CHAIRMAN: A combination.

MR. ANDRAS: There is a combination of them. Saskatchewan has two different systems, British Columbia has a third system, and Ontario has a fourth. This is a matter on which we have opinions, and I think we have expressed them, but we realize the provinces are quite likely to go in different directions to get the same result. In some provinces, we would be more critical than in others.

COMMISSIONER McCUTCHEON: What would you regard as the ideal?

MR. ANDRAS: The ability to pay, through some form of progressive taxation as income tax.

COMMISSIONER McCUTCHEON: You don't regard that as regressive?

MR. ANDRAS: No.

MR. JODOIN: There is the Trans-Canada Highway, for instance. I think this is more important than the Trans-Canada Highway. You will pardon the





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MR. ALLEN: The ability to pay.

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COMMITTEE MEMBER: You don't

believe that as progressive?

MR. ALLEN: No.

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principle, for instance. I think this is more important  
 than the Trans-Canada Railway. You will have a line



Andras

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comparison, I am sure, and certainly because of the ramifications of the B.N.A. Act that we are living under, we have to work it in the way Dr. Firestone has expressed himself, hoping it will be full coverage as much as possible throughout Canada.

COMMISSIONER FIRESTONE: If we may pursue this question of financing for a moment, sir, you would feel, sir, that income tax, the method of payment through income tax, may be the most equitable one from your point of view. I am just wondering how you would incorporate in such an approach the present system of employer-employee contribution to the financing of health care, or perhaps you may feel you may not wish to incorporate the present system into the new system of financing medical care services.

You do make reference in your brief to the fact that you do wish to have the employer contribution incorporated. I am just wondering if you also wish the employees' contribution incorporated and how such a system would work.

MR. ANDRAS: Well, at the present time we have a pattern in our collective bargaining arrangements whereby there may be a sharing of the cost of premiums or in other instances where the premiums are paid entirely by the employer. Unfortunately, we have no more information than the 1958 statistical form, but the pattern is there. Mr. Goldberg can elaborate on this, perhaps.

When the Ontario Hospital Insurance Act was passed, a number of employers immediately



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participation of the B.A.A. for that we are living

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to the fact that you do wish to have the employer

contribution incorporated. I am just wondering if you

also wish the employee's contribution incorporated and

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MR. ANDERSON: Well, at the present time

we have a system in our collective bargaining arrange-

ment whereby there may be a sharing of the cost of

premiums or in other instances where the premium are

paid entirely by the employer. In other words, we have

no more information than the 1955 statistical report,

but the pattern is there. Mr. Goldberg has also said

in this, perhaps.

Then the statistic is that health

and cost of care, a number of countries, particularly





Andras

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3 waived their contractual obligation to continue making  
4 premium payments as they had previously made. This  
5 resulted in a loss to our members in the form of wage  
6 payment.

7 COMMISSIONER McCUTCHEON: Why do you  
8 describe that as a loss in the form of wage payment  
9 when you are receiving something largely borne by the  
10 public treasury?

11 MR. ANDRAS: What we had in the Act  
12 before was, say, a bargain between the union and  
13 employer whereby the employer paid, in whole or in part,  
14 the premiums for, say, Blue Cross. That was so much  
15 a month, which we translated into so much per hour.  
16 Let's say the employer contracted to pay 3 cents per  
17 hour for that benefit. When the Act came into being  
18 some employers, I cannot say how many - I will refer  
19 to my colleague for this - immediately withdrew or  
20 ceased making this payment and said, "We don't have to  
21 pay it any more because now you are being taxed as a  
22 taxpayer. You will have to pay your premium for the  
23 insurance scheme now." This resulted, as far as we  
24 are concerned, in a loss of income of 3 cents an hour.

25 MR. GOLDBERG: We don't have accurate  
26 statistics of how many employers followed this step.  
27 Fortunately, most of them didn't. When they were  
28 making contributions to privately-administered hospital  
29 plans, they continued making contributions to the publicly-  
30 administered plan.





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4 There were some employers who, previous to the introduction  
5 of the public plan in Ontario had been making contributions  
6 on behalf of employees, either part of the total premium  
7 or the total premium for the private plan, but when the  
8 public plan was introduced they ceased making contributions  
9 since the law required the employee as the ultimate  
10 responsibility for paying the premium. Therefore, there  
11 was a conflict in the law, the hospital plan made the  
12 employer responsible, the Labour Relations Act had a  
13 responsibility to continue collective bargaining obliga-  
14 tions and yet certain employers ceased to continue their  
15 obligation and shifted the responsibility to the employee  
16 to pay the premium. This happened in a substantial  
17 number of cases although I could not tell you the exact  
18 number.

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20 COMMISSIONER McCUTCHEON: Because that  
21 is what the Government said they should do.

22  
23 MR. GOLDBERG: Well, if that is so,  
24 I think what Mr. Andras is saying, the legislation we  
25 would recommend would say otherwise.

26  
27 COMMISSIONER FIRESTONE: Well now,  
28 Mr. Andras, how would this scheme work in the future as  
29 far as financing of medical care is concerned and the  
30 employer's contribution?

THE CHAIRMAN: That is, I take it, in  
the situation that you are recommending of no premiums?

COMMISSIONER FIRESTONE: That is right.  
You remember you said you wished to have it paid through  
income tax and I am just trying to visualize how employer  
contribution comes into that.



there were some employers who, previous to the introduction of the public plan in Ontario had been making contributions on behalf of employees, either part of the total premium or the total premium for the private plan, but when the public plan was introduced they ceased making contributions

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is what the Government said they should do.  
MR. GOLDBERG: Well, if that is so,

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COMMISSIONER TWIN: Well, yes,

Mr. Andrus, now would this scheme work in the future as

far as financing of medical care is concerned and the

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THE CHAIRMAN: That is, I take it, in

the situation that you are recommending of no premium.

COMMISSIONER TWIN: That is right.

you remember you said you wished to have it paid through

income tax and I am just trying to visualize how you cover

contributions comes into that.



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Mr. Andras, I must give you a two-pronged answer; if there are no premiums whatever we would have to make a different kind of contractual arrangement with the employer to recapture our ----

COMMISSIONER McCUTCHEON: Would you visualize this as being purely personal income tax, financed through personal income tax?

MR. ANDRAS: Not necessarily.

COMMISSIONER McCUTCHEON: What right have you got to recapture something from the employer that you are now getting from the public purse and which the public is going to pay through increased corporate tax?

MR. ANDRAS: What we do when we bargain --

COMMISSIONER McCUTCHEON: I know what you do when you bargain.

MR. JODOIN: Maybe you do not.

MR. ANDRAS: Maybe I know better.

COMMISSIONER McCUTCHEON: Maybe you do.

MR. ANDRAS: What we do when we bargain is to bargain for cash, it may be a wage payment per hour or other unit of time, but we bargain for terms which have a monetary value which can be translated into cents per hour. Take the example of a statutory holiday, that would run from one half to three-quarters of a cent an hour. Now, we bargain for such packages and when we come out of a bargaining session, the employer says we have bought a package of X cents an hour. If the X cents includes my hypothetical three cents of hospital care and



Mr. Anderson, I must give you a two-

prolonged answer; if there are no premiums whatever we

would have to make a different kind of contractual

arrangement with the employer to recognize our

Commissioner McCutcheon: Would you

visualize this as being purely personal income tax,

financed through personal income tax?

Mr. Anderson: Not necessarily.

Commissioner McCutcheon: That might

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the public is going to pay through increased corporate

tax?

Mr. Anderson: What we do when we bargain

Commissioner McCutcheon: I know what

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Mr. Johnson: Maybe you do not.

Mr. Anderson: Maybe I know better.

Commissioner McCutcheon: Maybe you

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hour. Now, a bargain for such holidays and when we

come out of a bargaining session, the employer says we

have bought a package of X cents an hour. If the

the next hypothetical three cents of holiday is to be





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if for some reason the statute, for instance, the three cents goes by the board, the three cents that could have been paid in cash by the hour is no longer there and the employee is out of pocket three cents.

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COMMISSIONER McCUTCHEON: What you want to do is get your three cents and have the employer continue to pay the three cents somebody else, is that it?

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MR. ANDRAS: I do not think that is the case.

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COMMISSIONER McCUTCHEON: It seems to me that is the position you are putting yourself in.

13

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THE CHAIRMAN: I do not want to pursue this and I think we have probably carried it far enough. Is this not the position, for that three cents the employee has purchased his hospitalization.

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COMMISSIONER McCUTCHEON: Medical services.

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THE CHAIRMAN: Hospitalization in the example you used.

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MR. ANDRAS: The employee has bargained for three cents in one place rather than in another.

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THE CHAIRMAN: He has paid hospitalization?

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MR. ANDRAS: That is right.

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THE CHAIRMAN: If he gets hospitalization anyway he has got his cake whether he pays for that in one form or another, he is going to get the hospitalization and you want the additional three cents.

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MR. ANDRAS: We bargain primarily for money and we translate it into items.

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THE CHAIRMAN: I have understood you now.

MR. ANDRAS: The point I was trying to make, there are two ways of dealing with it. If there were a premium payment that would be a different matter.

THE CHAIRMAN: We are talking about where there is no premium payment. We cannot jump from one to another and carry on any intelligent discussion, we have to remain on the same plan.

MR. ANDRAS: Well, we would work on Dr. Firestone's assumption that some provinces might have a premium payment and others might have a sales tax arrangement.

THE CHAIRMAN: I straightened that out, because the answer would be different, so I brought you into the one context.

COMMISSIONER FIRESTONE: Can I be helpful by saying you suggested that the ideal method of payment would be through income tax. If such a system were adopted universally, then what would be the position of the employer contribution? Would that disappear and would you bargain yourselves with the employer as far as your ordinary demands are concerned and you would feel that the medical care costs had been taken in what you call an equitable method of financing, is that your point of view?

MR. ANDRAS: Yes, if it were done this way, it would be equitable.

COMMISSIONER FIRESTONE: That is the one system. Then, we go to the second part.





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THE CHAIRMAN: I have another question.

MR. [Name]: The point I was trying to

make, there are two ways of dealing with it. If there  
was a premium payment the would be a different matter.

THE CHAIRMAN: Is there anything about

there there is no premium payment. We cannot jump from  
one to another and carry on any intelligent discussion,  
we have to remain on the same level.

MR. [Name]: Well, we would work on

Mr. [Name]'s assumption that some provinces might  
have a premium payment and others might have a sales tax  
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THE CHAIRMAN: I straightened that

out, because the answer would be different, so I brought  
it into the one context.

COMMISSIONER [Name]: I am

mainly by saying you suggested that the ideal method of  
payment would be through income tax. If such a system  
were adopted universally, then what would be the position  
of the special contribution? Would that disappear and  
would you really compare it with the employer's share?  
You might demand the concerned and you would say  
that the ideal case occurs when both in that you are  
an equitable method of handling, is that your point?

MR. [Name]: Yes, it is more

equitable in principle.

COMMISSIONER [Name]: What is the

problem, then, we go to the same



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COMMISSIONER McCUTCHEON: What was the answer to the employer contribution, I did not get that?

COMMISSIONER FIRESTONE: The witness will deal with that question. What would happen to the employer contribution in case of the whole premium being paid on an income tax basis?

MR. ANDRAS: We would probably try to recapture it as part of our wage payment.

COMMISSIONER FIRESTONE: But it would not be a contribution under such a system to the health care costs?

MR. ANDRAS: I think administratively that would not be possible.

COMMISSIONER FIRESTONE: That is quite an adequate answer as far as I am concerned. I am just interested in your views, I am not interested in your labour problems, just your views of how to implement the plan you have put before us. If we can concentrate on the subject we will find it very helpful.

We go to the second part, assuming that there would be regional variations, some provinces would use the income tax approach, some a combination including premium, what would be the situation with respect to employers' contribution then?

MR. ANDRAS: If there is a premium then our answer is simpler to make. We would expect to see the transfer of the contribution from a private underwriter of whatever kind towards the public agency itself, and this would require merely modification or an amendment



CONFIDENTIAL - SECURITY: That was

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CONFIDENTIAL - SECURITY: That was

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paid on an income tax basis?

MR. ALDRICH: It would be a very

thing, but it is part of our wage system.

CONFIDENTIAL - SECURITY: It is

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there would be regional variations, how would you

use the income tax approach, with a contribution including

premium, what would be the situation with respect to

employer's contribution then?

MR. ALDRICH: If there is a

then can transfer is simpler to deal with, and it is

that a transfer of the contribution from a private employer

to the government would be a very big step, and it is

not clear whether this would be a very big step, and it is





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of the contract. It would be a fairly simple thing to do.

THE CHAIRMAN: Even if that premium was only one-quarter or one-third of what the hypothetical three cents an hour would work out to in a year? For instance, the premium, say in Saskatchewan, is \$24.00 and three cents an hour over a year would be \$50.00 or \$60.00 --- I do not know what it might be, it might be \$100.00 --- would you want the full three cents even if the premium was only a fraction of it?

MR. ANDRAS: Yes, we would want --- we would like redistribution of the three cents in other ways. This represents part of our package settlement, it is a contractual bargaining relationship there.

COMMISSIONER FIRESTONE: Well now, under the present plans employees also make contributions, what would happen to the employees' contribution?

MR. ANDRAS: Well, that would depend on the situation if it is a public program.

COMMISSIONER FIRESTONE: Yes, we are talking about the sort of program which you have proposed but with regional variation and flexibility.

MR. ANDRAS: If the premium were one of sales tax or an income tax where there is no need for an earmarked employee contribution, then, of course, the employee would cease to make the contribution, he would have no alternative and I do not believe he would look for one.

COMMISSIONER McCUTCHEON: He might want to contribute it to the employer, he might want to



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of the contract. It would be a fairly simple thing to do.

THE CHAIRMAN: Even if that premium was only one-quarter of one-third of what the hypothetical three cents an hour would work out to in a year, for instance, the premium, say in Saskatchewan, is \$24.00 and the three cents an hour over a year would be \$50.00 or \$74.00 -- I do not know what it might be, it might be \$100.00 -- would you want the full three cents even if the premium was only a fraction of it?

MR. ALLEN: Yes, he would want --

we would like the redistribution of the three cents in other ways. This represents part of our package solution, it is a contractual bargaining relationship there.

COMMISSIONER FIRST: Will he --

under the present plans employees also make contributions, what would happen to the employees' contribution?

MR. ALLEN: Well, that would depend

on the situation if it is a public program.

COMMISSIONER FIRST: Yes, as are

talking about the sort of program which you have in mind, but with regional variation and flexibility.

of sales tax or an income tax where there is no need for an employer-employee contribution, then, of course, the employee would cease to make the contribution, we would have no alternative and I do not believe he would look for one.

would to contribute it to the employer, as a part of



Andras 11293

revise the contract.

MR. ANDRAS: I have strong doubts on the subject.

COMMISSIONER FIRESTONE: You say such a program, in your Paragraph 4, still on Page 6, would provide health care of the highest quality.

MR. ANDRAS: I am sorry if I misunderstood you, we said it should seek to provide health care.

COMMISSIONER FIRESTONE: Yes, it aims at providing health care of the highest quality. It has been suggested to us that under a state-operated program that it would be difficult to provide as high quality of medical care services as perhaps the public of Canada is seeking to obtain. Have you any views on the subject?

MR. ANDRAS: We have seen these statements and they seem to be merely either a sort of folklore or a value judgment. We have not found in the literature we have read substantiating evidence that this would be the case.

COMMISSIONER McCUTCHEON: I have no doubt you are much better informed than I am, but have you found any evidence to indicate that the morbidity rate or the mortality rate has improved in the United Kingdom since the introduction of the National Health Services Plan? There is either evidence or there is not.

MR. ANDRAS: I do not know that this is a fair question in this respect, I am not inferring prejudice on your part ---

COMMISSIONER McCUTCHEON: I am completely unprejudiced.





review the contract.

MR. ALPERT: I have some questions.

Thank you.

COMMISSIONER: Yes, you may ask.

For example, in your paragraph 4, still on page 6, would

provide health care of the highest quality.

MR. ALPERT: I am a new man. I am new.

Good, you, we said it should seek to provide health care.

COMMISSIONER: Yes, it does.

at providing health care of the highest quality. It has

been requested to us that under a state-owned system

that it would be difficult to provide as high quality

of medical care services as perhaps the public of Canada

is seeking to obtain. Have you any view on the subject?

MR. ALPERT: We have seen these other

agents and they seem to be merely a sort of follow-up

on a value judgment. We have not found in the literature

we have read substantiating evidence that this would be

the case.

COMMISSIONER: Now, I know

that you are much better informed than I am, but have

you found any evidence to indicate that the mortality

rate on the mortality rate has improved in the United

Kingdom since the introduction of the National Health

Service Plan? There is still evidence on there is not.

MR. ALPERT: I do not know that

is a fair question in this respect, I am not informed.

COMMISSIONER: Now, I am

Thank you.



Andras 11294

MR. ANDRAS: I am saying it is not fair in the sense that you have had in England a long period of health care which goes back 50 years. The Act that came in at the end of the War was the final extension of it.

COMMISSIONER McCUTCHEON: A pretty violent extension.

MR. ANDRAS: There have been a number of factors involved. Just last night I was reading one of a series of articles that appeared in the London Observer a few months ago and as luck would have it, I have only one of the series along with me, not the whole lot, because my briefcase holds only so much. This was written by Dr. Abraham Marcus and the first of the series he points out there have been a very great difference in rates, different kinds of people now are the statistics in morbidity, the older people rather than the younger people. We have more of the diseases of middle and old age now. A good health service would tend to point this up because if we discover these cases they would treat them, and, therefore, your statistics would reflect them. If you want this we will submit a supplement to you, but frankly I cannot give it to you now.

COMMISSIONER McCUTCHEON: I would be very happy if you submitted to us any evidence. If you do not regard the United Kingdom as proper, let us take West Germany or Sweden or Norway, any evidence to show that comprehensive universally available health plan has resulted in a significant improvement in morbidity and mortality as compared to the experience in the United



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MR. WATSON: I am saying it is not

him in the sense that you have had in England a long  
period of health care which goes back 50 years. The  
fact that came in at the end of the war was the first  
extension of it.

COMMUNISTIC NOTION: A pretty

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MR. WATSON: There have been a number

of factors involved. Just last night I was reading one  
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The new. A good health service would tend to point this  
out, because if we discover these cases they would treat  
them, and, therefore, your statistics would reflect that.  
I am sure this we will admit a supplement to you, and  
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has resulted in a significant improvement in mortality  
and mortality as compared to the extension in the United





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S Dates and in Canada in the same period.

MR. ANDRAS: We might have a look.

COMMISSIONER FIRESTONE: One point that has been made to us on quality of medical care is that the extension of such services would cause difficulties in this program with the limited supply of health personnel whether doctors or dentists or nurses, but with the existing resources they would have to be spread over a larger volume of services. Now, doctors are human beings like everyone else and there are just so many hours in the day and the existing quality of service might suffer as a result of that. Have you any ideas on this subject?



States and in Canada in the same period.

MR. ALEXANDER: Is that have a look.

COMMISSIONER: Yes, sir.

that has been made to as on quality of medical care  
is that the extension of such services would cause diffi-  
culty in this program with the limited supply of health  
personnel whether doctors or dentists or nurses, but  
with the existing resources they would have to be spread  
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many hours in the day and the existing quality of service  
might suffer as a result of that. Have you any ideas on  
this subject?



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4 MR. ANDRAS:-- You are assuming, if I  
5 understand you correctly, Dr. Firestone, that the status  
6 quo in terms of personnel would remain unchanged. We  
7 are not.

8 COMMISSIONER FIRESTONE: I am not  
9 assuming anything, Mr. Andras. I am just passing on to  
10 you the sort of comments we have received from people  
11 in some of the health professions anticipating that  
12 there may be some expansion of the health personnel over  
13 a given period of time, but you appreciate if you  
14 introduce a program at a given point in time with the  
15 bodies you have got sooner or later, presumably supply  
16 and demand will come into balance, but until that point  
17 is reached, for example five or ten years, quality of  
18 medical care service and other health care service  
19 would suffer as the result. That is the sort of argument  
20 that is being put to us. Is it valid or not in your  
21 opinion.

22 MR. ANDRAS: No, We think government  
23 has two alternatives, one is to introduce the program  
24 at once and a lot of people will take advantage of it  
25 and the other is to wait until the resources are available.  
26 We examined these alternatives. We came to the con-  
27 clusion if we were to ask government to wait until  
28 resources were available we would be entering a never  
29 never land. We think from the point of view of the lesser  
30 evil, if you want to put it in those terms, we would  
plump, as we have done for an immediate program. We  
would also urge and we have urged that those involved  
not merely open wide the doors and ask all the people to







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3 help themselves, but to organize or reorganized all  
4 personnel and facilities so as to provide for optimum  
5 use and most economic and efficient use. We appreciate  
6 the fact there would be some people taking services  
7 or getting services if a plan were introduced than there  
8 are at the present time. That is one risk. It is  
9 inevitable. We think it is one worth taking because  
10 very many people are not getting any health care at  
11 all.

12 COMMISSIONER McCUTCHEON: Who are  
13 those people?

14 THE CHAIRMAN: Let us keep in one  
15 category at a time. That is a question we are going to  
16 put to you in a moment.

17 COMMISSIONER FIRESTONE: Thank you,  
18 Mr. Chairman. Mr. Andras, is the implication of your  
19 answer that if a program were introduced and substantially  
20 increased demands for medical care and other health care  
21 services without a corresponding immediate increase in  
22 terms of numbers of bodies then this means reduction in  
23 the quality of medical care services even if optimum  
24 redistribution of resources may take five or ten years  
25 until this high quality of care service can actually  
26 be achieved before the balance of supply and demand has  
27 been reached.

28 MR. ANDRAS: It is a risk. I would see  
29 it as a risk, but it is a question again of the use of  
30 resources and that risk can be minimized.

31 COMMISSIONER FIRESTONE: Assuming that  
32 that risk is minimized and this, in fact, means a



help themselves, but to depend on organized all  
personal and facilities so as to avoid a serious  
use and most economic and efficient use, we are  
the fact there would be some people taking services  
on the line services if a plan were introduced that would  
are at the present time. That is one risk. It is  
inevitable. We think it is one worth taking because  
very many people are not getting any health care at  
all.

THE CHAIRMAN: Let us keep in mind  
category at a time. That is a question we are going to  
put to you in a moment.

MR. CHAIRMAN: Mr. Anderson, is the implication of your  
answer that if a program were introduced and established which  
increased demands for medical care and other health care  
services without a corresponding immediate increase in  
terms of number of facilities then this would tend to  
the quality of medical care services even if optimal  
redistribution of resources may take five or ten years  
until this high quality of care services are available  
be achieved before the balance of supply and demand has  
been reached.

MR. ANDERSON: It is a risk. I would see  
it as a risk, but it is a question as to the amount  
of resources and that risk can be minimized.  
That risk is minimized and that, in fact, is a





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4 temporary reduction in the quality of medical care  
5 services would the congress support such a national  
6 program in the interest of getting over the long term  
7 higher quality service again but starting with a  
8 universal program pretty shortly?

9 MR. ANDRAS: Our suggestion has been  
10 that we should do so. We support a universal program  
11 and we have suggested a two-stage procedure.

12 COMMISSIONER FIRESTONE: But you are  
13 prepared to take that risk that for a period there may  
14 be a reduction in the quality of health care services?

15 MR. ANDRAS: Well, I mean to say there  
16 may be.

17 COMMISSIONER FIRESTONE: We have been  
18 told by members of the medical profession that there  
19 will be. I am putting it as maybe because we just don't  
20 know what the future holds.

21 MR. ANDRAS: That is true.

22 COMMISSIONER FIRESTONE: You are  
23 prepared to take that risk?

24 MR. ANDRAS: Yes.

25 COMMISSIONER FIRESTONE: Perhaps we  
26 could turn now to the question that the Chairman deferred.

27 COMMISSIONER McCUTCHEON: Mr. Andras,  
28 who are the people who are not receiving health care  
29 today?

30 MR. ANDRAS: There are a number of  
people as the Sickness Survey indicated who make little  
or no use of the health facilities in the country for  
a variety of reasons. One is that the facilities are not



territory... in the... of...  
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... in the... of...  
... service... but... with...  
... universal... that...

MR. ANKAS: ... suggestion has been  
... we should do... The... universal...  
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... be a reduction in the quality of health care services?  
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... may be.

COMMISSIONER: ... We have been  
... told by members of the medical profession that there  
... will be. I am putting it as maybe because we just don't  
... know what the future holds.

MR. ANKAS: That is true.  
COMMISSIONER: ...  
... prepared to take that risk?

MR. ANKAS: ...  
COMMISSIONER: ...  
... would turn now to the question that the...  
... who are the people who are not receiving health care  
... today?

MR. ANKAS: ... There are a number of  
... people as the...  
... in the use of the health... in the country...  
... a variety of reasons. One is that the facilities are...



Andras

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there. They may be living in remote areas.

COMMISSIONER McCUTCHEON: That is not an economic reason.

MR. ANDRAS: No, not for them, except the cost of getting in an area where the services are available. There are people who for reasons of low income are not able to get all the health care they require. In statistical terms it is difficult to give you the figures of 1962 because the Canadian Sickness Survey is now some years old, but it indicated that there was a considerable portion of the population that was not getting any care or was not getting much care.

THE CHAIRMAN: Mr. Andras, we have been going from one province to another and one capital city to another been putting the question to the welfare people, to those at the level where from the economic standpoint you might say medical care would be most difficult to obtain on that basis, and we have yet to be told any one who has gone without medical care merely for want of money.

MR. ANDRAS: Mr. Chairman, the people that were described by the welfare people would get medical care because these are their clients and they make it their business to see that they get it. If you want to stratify our population you have a stratum or strata above these people who cannot pass a means test or needs test. They just have enough money beyond that, but these are the people who encounter real difficulties because they cannot pay their doctors' bills or they cannot pay their dentists' bills. In fact the Sickness





there. They may be living in remote areas.

Q. Now, if that is the case, what is not

an economic reason.

A. Well, no, not for them, except

the cost of getting in an area where the services are

available. There are people who for reasons of low

income are not able to get all the health care that

required. In statistical terms it is difficult to give

you the figures of 1952 because the Canadian statistics

survey is now some years old, but it indicated that

there was a considerable portion of the population that

was not getting any care or was not getting much care.

THE CHAIRMAN: Mr. Andrews, we have

been going from one province to another and one capital

city to another been putting the question to the welfare

people, to those at the level where from the economic

standpoint you might say medical care would be most

difficult to obtain on that basis, and we have yet to

be told any one who has gone without medical care merely

for lack of money.

MR. ANDREWS: Mr. Chairman, the people

that were covered by the welfare people would get

medical care because these are their rights and they

make it their business to see that they get it. If you

want to start by our legislation you have a standard of

standards above these people who cannot pass a means test

or needs test. They don't have enough money beyond that,

but these are the people who encounter real difficulties

because they cannot pay their doctors' bills or they

cannot pay their dentists' bills. In fact the sickness



Andras

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4 Survey indicated a very clear correlation between  
5 utilization or inversed utilization, if my jargon is  
6 correct, between utilization and income. In the case  
7 of dentistry it was an appalling figure. I remember  
8 being shocked by the low figure of utilization of  
9 dental service. It was also true with medical care.  
10 For example, the membership in the voluntary plans is  
11 directly related to income. The higher your family  
12 income the larger proportion of that group belong to  
13 P.S.I. or Blue Cross or whatever it happens to be, a  
14 commercial carrier as the case may be.

15 THE CHAIRMAN: Those were not the figures  
16 we got from the Windsor Plan, for example.

17 MR. ANDRAS: The Windsor Plan exists  
18 in two counties or three counties, I cannot recall  
19 precisely.

20 THE CHAIRMAN: There was no suggestion  
21 of an income proposition at all there, nor in the figures  
22 of P.S.I. or Manitoba Medical or Maritime Medical.

23 MR. ANDRAS: Well, Windsor is U.A.W.  
24 The U.A.W. has bargained fringe for many years. The  
25 large part of the population in Windsor as the result  
26 of collective bargaining are covered by Windsor Medical  
27 Services. In terms of coverage the Trans Canada Medical  
28 Plan -- there is a real problem in carrying so much  
29 evidence. You can never find it.

30 THE CHAIRMAN: I used to find the  
back of an envelope was as good a place for a brief as  
anywhere.

MR. ANDRAS: I think perhaps we should



Survey indicated a very clear correlation between utilization or increased utilization, and income. In the context, between utilization and income. In the context of dentistry it was an appealing figure. I remember being shocked by the low figure of utilization. It was also true that dental services. For example, the membership in the voluntary plan is directly related to income. The higher your family income the larger proportion of that group belong to P.S.I. or Blue Cross or whatever it happens to be. commercial carrier as the case may be.

THE CHAIRMAN: Those were not the things

we got from the Windsor Plan, for example.

MR. ANDERSON: The Windsor Plan is a

in two counties or three counties, I don't recall precisely.

THE CHAIRMAN: There was no discussion of an income proposition at all there, nor in the case of P.S.I. or Manitoba Medical or whatever.

MR. ANDERSON: Well, I think in U.S.

The U.A.W. has maintained things for many years. In large part of the population in Windsor as far as of collective bargaining are covered by Windsor Medical Services. In terms of coverage the Windsor Medical Plan -- there is a real problem in carrying out the plan. You can never find it.

THE CHAIRMAN: I don't think

back of an envelope was as good a plan as the Windsor

MR. ANDERSON: I think that was the





Andras

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4 borrow you and put you at this side of the table. I  
5 have here an exhibit from the T.C.M.P. I think it must  
6 be public or they would not have mailed it to us.

7 COMMISSIONER McCUTCHEON: A masterpiece  
8 of understatement.

9 MR. ANDRAS: This consists of their  
10 plans in the percentage of the population covered by  
11 them, obviously this doesn't mean these are all the  
12 people covered by prepayment plans.

13 THE CHAIRMAN: They don't report on  
14 all of the, some 29 co-operative plans in Ontario?

15 MR. ANDRAS: This covers only  
16 medically-sponsored.

17 THE CHAIRMAN: The medical co-op in  
18 Saskatoon, many of the grass root plans are not covered  
19 in these Trans Canada figures.

20 MR. ANDRAS: We do have for that matter  
21 the figures, if I start going through this archaeological  
22 process. As of December 31st, 1960 -- this is compiled  
23 by the insurance industry -- I am sorry I have to give  
24 them credit for something. They have coverage in 1960 -  
25 51.8% of the population were covered with surgical  
26 benefits. That is all kinds of carriers. In the same  
27 year 48% exactly with medical benefits and 11.3% forms  
28 major medical benefits.

29 THE CHAIRMAN: That was an exhibit  
30 filed before us.

MR. ANDRAS: I was not aware of that.  
This was in my files and I brought it along. It is  
really not relevant.



bottom year and put you at this side of the table.  
have here an exhibit from the T.I.B. I will be glad  
be public or they would not have called it so.

COMMISSIONER: Yes, it is a representative  
of understatement.  
MR. ANDERSON: This consists of the  
plans in the percentage of the population covered by  
them, obviously this doesn't mean a great deal to  
people covered by prepayment plans.

THE CHAIRMAN: They don't report on  
all of the, some 19 co-operative plans in Ontario.  
MR. ANDERSON: This covers only

THE CHAIRMAN: The medical group in  
Saskatoon, many of the cross road plans are not covered  
in these Trans Canada figures.  
MR. ANDERSON: We do have for that matter  
the figures, if I start going through this and making  
process. As of December 31st, 1960 -- this is completed  
by the insurance industry -- I am sorry I have to give  
them credit for something. They have covered in 1960  
51.84 of the population were covered with medical  
benefits. That is all kinds of coverage, in the same  
year 54.5 exactly with medical benefits and 11.7 for  
major medical benefits.

THE CHAIRMAN: But was an exhibit  
filed before us.  
MR. ANDERSON: I was not aware of that.  
This was in my files and I know it is. It is  
really not relevant.



Andras

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THE CHAIRMAN: It is relevant.

MR. ANDRAS: The point is there are a very considerable number of people in Canada who have no coverage.

THE CHAIRMAN: That is quite true. There is nobody suggesting otherwise.

MR. ANDRAS: Some are not covered because they don't need to, they have the resources to pay directly to the physicians. There are a very considerable number who do not belong because they have not got the money and we are concerned about them. These people cannot afford to pay premium payments, then they are rather less likely to be able to afford to make a direct payment to the physician.

COMMISSIONER FIRESTONE: If we may now turn to paragraph 5 again, still on page 6. It is really paragraph 5 in what you call in the margin paragraph 9. You say such a premium should be equitably financed. We have discussed what equitable financing means. Then you say and I quote:

"And free of any co-insurance, deductibles  
"or other financial deterrents against  
"full use".

In the body of your submission you set out the reasons and as I recall one of the main reasons is you don't want to discourage anyone who needs the service from getting that service.

MR. ANDRAS: Partly for that reason, and partly because it makes a direct tax.

COMMISSIONER FIRESTONE: I said one





THE CHAIRMAN: To the first question, Mr. A. I think the answer is that there is a very considerable number of people in this country who have

THE CHAIRMAN: The answer is that there is nobody suffering from it because they don't need it, even though the business to pay directly to the physician. There is a very considerable number who do not believe that they have not got the money and we are concerned about that. That people cannot afford to pay premium payments, even though they are rather less likely to be able to afford to make a direct payment to the physician.

CHAIRMAN: WHEN YOU SAY THAT IT IS NOW TURN TO PARAGRAPH 5 AGAIN, WILL YOU PLEASE? IT IS REALLY PARAGRAPH 5 IN WHAT YOU CALL IN THE FIRST PARAGRAPH 8. YOU SAY THAT A CERTAIN NUMBER OF PEOPLE ARE FINANCED. WE HAVE DISCUSSED THAT QUESTION BEFORE AND IT MEANS, THEN YOU SAY AND I QUOTE:

"And free of any co-insurance, which is one of our financial statements as a result."

"Full rate."

In the body of your submission you say that the reason and as I recall one of the main reasons is that you want to discriminate against those who are the least able to afford that service.

MR. A: That is exactly the point, and exactly because it makes a difference to the one



Andras

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3 reason. There is also direct tax.

4 MR. ANDRAS: Yes.

5 COMMISSIONER FIRESTONE: It has been  
6 suggested to us by some of the pharmaceutical groups  
7 in the case of drugs there are certain economic  
8 advantages to be derived if there were a small co-insurance  
9 factor in operation, not so much to discourage people  
10 from purchasing drugs when they need them but to  
11 discourage them from purchasing drugs in excess of  
12 current needs and partly also because it would be a  
13 factor contributing to the cost and the financing of  
14 such a service. When I asked them what kind of co-  
15 insurance they had in mind they were thinking of some-  
16 thing like 50¢ or \$1.00 per prescription. What are  
17 your views on this particular point?

18 MR. ANDRAS: I would say, Dr. Firestone,  
19 that really this is not in the control of the consumer  
20 of the drug. This is a matter of the opinion of the  
21 prescriber. The physician is the one who furnishes me  
22 with a prescription. I take it to the drug store. I  
23 do not walk in and buy drugs whose names I cannot even  
24 pronounce. If I go to a physician and he says, Mr.  
25 Andras I am prescribing something you will have to take  
26 three times a day, then that presumably is the necessary  
27 procedure that is prescribed and I can't see why there  
28 should be a utilization cost or deterrent cost because  
29 he does not want to deter me from using it. He wants  
30 me to use it for my own well-being. I don't see  
logically the utilization charge there at all.



reason. There is also direct tax

Mr. [Name] [Address]

suggested to us by some of the pharmaceutical firms

in the case of drugs in the are certain countries

advantages to a dealer if there were a small co-operative

factor in operation, not a dealer in a dealer's shop

from purchasing drugs when they need them but to

discounts then from purchasing drugs in excess of

current needs and not also because it would be a

factor contributing to the cost and the [Name] of

such a service. When I asked them what kind of co-

operation they had in mind they were told that it was

thing like [Name] or [Name] has presentation. That was

your views on this particular point?

Mr. [Name]. I would say, Mr. [Name],

that really this is not in the control of the [Name]

of the drug. This is a matter of the opinion of the

association. The decision is the one who [Name] has no

with a prescription. I take it to the same [Name]. I

do not wish in any way to [Name] [Name] I cannot [Name]

prescription. If I [Name] a [Name] and [Name] [Name]

And [Name] I am [Name] [Name] you will have to take

three [Name] a day, then that [Name] is the [Name]

procedure that is [Name] and I don't see why these

should be a [Name] in cost of [Name] [Name] [Name]

he does not want to [Name] [Name] [Name] [Name]

me to use it [Name] [Name] [Name] [Name] [Name]

indication the [Name] [Name] [Name] [Name] [Name]





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4 COMMISSIONER FIRESTONE: Well, the  
5 point that was made to us, I am putting it in the form  
6 of a question, but not necessarily holding the view one  
7 way or the other, but in the U.K., it was found that the  
8 shelves of many, many people were bulging with prescribed  
9 drugs that were never used, and the costs of such a  
10 scheme were running away, and I am sure you would like  
11 to see the tax dollar used as efficiently, because if  
12 you were to misuse it for drugs, or any other purpose,  
13 some other, justifiable health service would suffer as  
14 a result.

15 We have had no experience of this,  
16 but judging by the experience of other countries, they  
17 have found this to be a necessary arrangement to increase  
18 the most effective use of limited funds.

19 MR. ANDRAS: Well, if the shelves of  
20 the British medical cabinets were full of drugs that  
21 were not being used ---

22 THE CHAIRMAN: Not the medical cabinets.  
23 The patients', the people at home.

24 MR. ANDRAS: The patients' cabinets  
25 in their bathrooms, if they were bulging with drugs that  
26 were prescribed by physicians and not used, you must  
27 place the responsibility on other than the consumer.

28 COMMISSIONER McCUTCHEON: Do you know  
29 of any country that has a public health insurance scheme  
30 in the western world that provides a complete and exhaustive  
list of drugs without a direct charge at the time of  
using, or that provides all drugs?

MR. ANDRAS: In New Zealand, if I



--- been gained ton crew



Andras 11305

remember correctly, they have schedules of drugs --

COMMISSIONER McCUTCHEON: Limited.

MR. ANDRAS: That they provide to the pharmacists and the doctors ----

COMMISSIONER McCUTCHEON: A limited schedule though, not all drugs.

MR. ANDRAS: A schedule, yes. I think if it is a question of degree, we would subscribe to the provision of necessary drugs. Now, this is a judgment which the physician makes.

COMMISSIONER McCUTCHEON: It would be a judgment that the politician would make.

MR. ANDRAS: Mr. McCutcheon, with much respect, I subscribe to the principle of the sovereignty of Parliament, and I think Parliament, consisting of human beings, makes errors in judgment, but it is also able to correct those errors.

I would venture to say, so far as we are concerned, we are not interested in the consumption of drugs for the sake of consumption itself. What we are interested in is the provision of drugs as part of the armamentarium of health care. We don't want the provision arranged in such a fashion that some people, for lack of funds, will be unable to get the care they require, whether an injection, or a pill, or a visit in a doctor's office, or a surgical procedure, or whatever it may be. We are as much interested in economy of care as anybody in this country.

COMMISSIONER McCUTCHEON: Would you agree with me that in your recommendation for the provision





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THE CHAIRMAN: Yes.

MR. ANDERSON: That they have no schedule --

pharmacists and the doctors --

COMMISSIONER MONTGOMERY: A little

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as anybody in this country.

agrees with me that in your recommendation for the



Andras 11306

of drugs you are going farther than Great Britain, New Zealand, Germany, Norway, Sweden?

MR. ANDRAS: Yes, we are objecting to utilization charges, or co-insurance charges.

COMMISSIONER FIRESTONE: But you would be prepared to endorse an approach that would bind the issuance of drugs under that plan to what you call prescription drugs?

MR. ANDRAS: Necessary drugs.

COMMISSIONER FIRESTONE: Necessary prescription drugs, leaving it to the judgment of the physician ----

THE CHAIRMAN: We are always talking about prescription drugs here.

COMMISSIONER FIRESTONE: Are you differentiating between drugs that the doctor prescribes that are necessary, and those that the doctor prescribes that are unnecessary?

MR. ANDRAS: I would hope that the doctor wouldn't prescribe unnecessary drugs.

COMMISSIONER FIRESTONE: Do you mean by necessary, prescription drugs?

MR. ANDRAS: Prescription drugs, yes.

COMMISSIONER FIRESTONE: May I now turn to Paragraph 6, on Page 6, in which you say that: "Such a plan should be organized to provide optimum distribution and coordination of the various type of health services, agencies and personnel". I take it the term coordination refers to a plan of medical care services developed by Governments in cooperation with the



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Andras 11307

profession, the profession in the case of medical care services being the physicians. Is that understanding correct?

MR. ANDRAS: Yes.

COMMISSIONER FIRESTONE: Now, sir, what happens if some of the physicians feel that they are not prepared, or the majority of physicians in the province feel that they are not prepared to cooperate under a particular program, because they feel that for one reason or the other it is not ---

THE CHAIRMAN: It is unacceptable.

COMMISSIONER FIRESTONE: It is unacceptable.

MR. ANDRAS: If they were not prepared to do so, and if they were prepared, or able to carry out this feeling on their part, they would, of course, be making the program inoperative if they were successful in doing what they set out to do.

My own feeling concerning the medical profession is that by and large there seems to be an obvious exception growing up in our community, but by and large they respect the law. They have a very great sense of devotion to their patients, and I think if a program were to be introduced, they would cooperate with it.

We have in our brief provided for the right of the organized practitioner to be represented through representatives of their own choosing, and to negotiate, to use our parlance, with the powers that be for the conditions under which they would operate, but assuming a program was in effect that enjoyed the support



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MR. WATSON: Yes

REPRESENTATIVE: Now, sir,

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Andras 11308

of the people, then I think they would feel obliged to serve under it.

THE CHAIRMAN: Supposing in such a program they were not given the privilege of being represented by those of their own choosing?

MR. ANDRAS: Well, you place hypothetical questions.

THE CHAIRMAN: No, I am placing a practical question, where the Government authority appoints, selects the personnel?

MR. ANDRAS: For the administrative body do you mean?

THE CHAIRMAN: For the administrative body, selects, and has the power to continue or discontinue that person in office?

MR. ANDRAS: To my knowledge, in most administrative agencies you make no differences, Mr. Chairman. I don't profess to be an authority of all the agencies in this country.

THE CHAIRMAN: I don't have to go very far. I am just saying in Canada.

MR. ANDRAS: In Canada I know of a number of agencies where the people on the board serve by appointment.

THE CHAIRMAN: No, but I mean we have only one program in Canada that approximates anything like what we are talking about here this morning.

MR. ANDRAS: It is my impression that the organized profession is asked to name appointees to the board. If the province has simply said: "We will





of the people, and I think they would feel obliged to  
serve under it.

Their main business is to

program they are not given the privilege of being

represented by those of their own country.

It is not a well, and also from the

That is, I am not a

practical question, where the Government authority is

exists the Government

It is not a well, and also from the

body as you mean

The Government is not a well, and also from the

body, defects, and the power of the Government is

time that person is

It is not a well, and also from the

administrative system as you mean is different, and

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It is not a well, and also from the

number of agencies that are on the road, and

by appointment.

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what we are talking about here is

It is not a well, and also from the

the organized institution is not a well, and also from the

the people. If the people are not a well, and also from the



Andras 111309

choose Dick, and Tom, and Harry, regardless of what  
you think ----

THE CHAIRMAN: By the statute that  
is what the province has taken, the Commission is appointed  
by the Lieutenant Governor in Council. It may well say:  
"Well, we will ask John Smith who he would like to have",  
but there is no statement in the statute saying that they  
will accept the recommendation of John Smith.

MR. ANDRAS: You have two aspects to  
legislation.

THE CHAIRMAN: You are saying a group  
that will be represented by persons of their own choosing,  
so I put it to you, do you envisage in that by statute  
that the representatives of the profession would sit, the  
delegates of the profession would sit as of right on the  
governing body?

MR. ANDRAS: I would think that the  
Government, or the Lieutenant Governor in Council, or the  
Governor in Council should seek nominations. This is a  
procedure that we have supported very energetically in  
our ---

THE CHAIRMAN: Should seek and accept  
nominations?

MR. JODOIN: That is right.

COMMISSIONER McCUTCHEON: But in fact  
you say this is a position you have supported, and I  
know you have, but in fact you have been disappointed ---

MR. ANDRAS: Right.

COMMISSIONER FIRESTONE: On this  
question of cooperation between the medical profession and a



choose one, and then, and then, the whole of the

you think ---

THE CHAIRMAN: The first question is

is what the province has to say, and the question is whether

by the Lieutenant Governor in Council, is any well say:

"well, we will send down letters and we will take to them,"

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THE CHAIRMAN: I will ask you a couple

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now you have, but in fact you have no right to say

THE CHAIRMAN: I will ask you a couple

THE CHAIRMAN: I will ask you a couple

question of co-operation between the two bodies, or





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Government body charged with the responsibility of administering that plan. Did I understand you correctly, and if I didn't, please correct me, that there would be bargaining, or discussions between the providers of the medical care service and the people that administrate the program as to the rewards for the service which the medical profession renders?

MR. ANDRAS: We said that this should be the case.

COMMISSIONER FIRESTONE: Did I understand you correctly?

MR. ANDRAS: That is right.

COMMISSIONER FIRESTONE: Well now, sir, how would this work in practice, when you have on the one hand a group of professional people, on the other hand a Government agency, even though it is perhaps, you call it a commission or a board, or whatever, it is in fact an extended arm of Government. Now, how would professional people bargain with Government?

MR. ANDRAS: Well, they bargain with Government right now. As a matter of fact under various Provincial programs the medical profession provides health care services to elderly people, or people on assistance. They get paid for it in a certain way, I don't know the precise amounts, but they have worked over the years at conclusions as to what is an equitable situation. This is no novelty, either to the profession or to the Crown.

COMMISSIONER FIRESTONE: This is quite correct, but you will recall, sir, that in this particular case the medical profession is obtaining the





Andras 11311

bulk of its income from private practice, and only a marginal portion of its income comes from these arrangements, so if they don't work out a satisfactory arrangement on this marginal, it does not affect their overall income considerably, but in this case it is different. Almost all their income will come from that source. I say almost, because you admit there could be some physicians outside that plan. Would you not say that that plan is a little different, and puts the medical profession in a more difficult situation than it is at the moment?

MR. ANDRAS: It is somewhat different, but we must bear in mind that in all our provinces the medical profession now receives a good deal of its income as a result of third party arrangements, through the commercial carriers, through the non-profit plans, through the cooperative plans, so that there are a considerable number of physicians who are already bound by agreements with schedules of fees, or percentages of schedules of fees.

What I am suggesting to you is that what you are suggesting is an expansion of an already existing arrangement. The parties are familiar with it and accustomed to the discipline of such an arrangement. You perhaps have more in mind than what you said, so I suggest that in that case you follow up on it.

COMMISSIONER FIRESTONE: May I suggest that I haven't suggested anything to you. I am just asking questions as to what your views are.

MR. ANDRAS: I am trying to anticipate





Dr. [Name]

half of its income from outside sources, and of its marginal portion of its income comes from these arrangements, so if they don't want a satisfactory arrangement on this marginal, it does not affect their overall income considerably, but in some cases it is different. Almost all their income will come from that source, I

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Dr. [Name]: I am not suggesting anything to you. I am just asking questions as to what your views are. Dr. [Name]: I am not suggesting anything to you. I am just asking



Andras 11312

your next move.

COMMISSIONER FIRESTONE: I appreciate your cooperative spirit and the manner in which you deal with the questions.

I am just wondering how this would work in practice, if the medical profession were to come to the Commission, the Government-appointed body, and say: "Look, our costs are going up, and we really should have a 5% increase in our fees", or whatever method of payment has been worked out in this particular case, and the Commission will say: "I am sorry, fellows, but the Government has allotted to us X million dollars, and we just cannot raise your fees as yet. Please come back to us next year. We love you dearly, but we just haven't got it". Now, what happens in this case?

MR. ANDRAS: One of two things can happen, depending on the arrangements that are worked out. If there cannot be on the one hand an arbitrary decision made on the lines you have suggested, there can on the other hand be a dispute settlement procedure, adjusted to the justice of the doctors' demands, or the injustice of the Government's reply, as the case may be, so it does not necessarily follow that if the Government says we love you, but we cannot give you any more money, that this is a final solution.



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Andras

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COMMISSIONER McCUTCHEON: Are you talking about compulsory arbitration?

MR. ANDRAS: It doesn't necessarily have to be, although arbitration is a common procedure in Canada.

COMMISSIONER McCUTCHEON: I used the word "compulsory".

MR. ANDRAS: We are very familiar with it; it doesn't scare us.

COMMISSIONER McCUTCHEON: Are you talking about an arbitration where the decision of the arbitrator is binding on both parties?

MR. ANDRAS: Yes, that is right; there would be an award.

COMMISSIONER McCUTCHEON: Which would be binding? There are lots of awards made in labour disputes which are not accepted.

MR. ANDRAS: There are a few have gone to the courts, but in our procedures arbitration awards are binding.

COMMISSIONER McCUTCHEON: What about withdrawal of service? Would you contemplate that as a bargaining weapon?

MR. ANDRAS: If the C.M.A. wants to join our Congress I think we would then give consideration to the use of that weapon.

I would point out to you that another trade union in our Congress - we are not holding out any offer of affiliation, although I think they would be well-advised to join us, as a matter of fact. But



to King as at court and by the King of

the King of the Netherlands.

have to be, of course, and there is a great possibility

in Canada.

There is no doubt that the

word "compulsory".

Mr. WILSON: He says that

with it; it doesn't seem as

compulsory as it seems to be.

talking about an arbitration, where the decision of

the arbitrator is binding on both parties.

Mr. ARTHUR: Yes, that is right;

there would be an award.

COMPULSORY ARBITRATION. Would you

be thinking? There are lots of cases where it is

disputed which are not accepted.

Mr. WILSON: There are a few cases where

to the court, but in our experience the arbitration award

is binding.

QUESTIONS OF THE COURT: What about

with regard to the award? You are saying that the

arbitration award

Mr. ARTHUR: He says that

from our point of view I think we would give our award

then to the use of that award.

I would like to know what the

trade union is all about - we are not

any other of this kind, I think that

be well-known to the public, as a matter of fact.



Andras

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it doesn't necessarily follow that every economic institution must apply or use withdrawal of service. Our firefighters, for example, don't.

COMMISSIONER FIRESTONE: Would you explain to us, Mr. Andras, whether, in that paragraph 7 on page 6, where you state that such a plan would include an appeals procedure, that appeals procedure applies both to the recipients of health care services as well as the providing of health care services?

MR. ANDRAS: We deal with it in our brief in rather brief detail, if I can find it.

THE CHAIRMAN: Paragraph 191.

MR. ANDRAS: We say in paragraph 192:

"There are a variety of areas in which such an appeals procedure could operate: the determination of coverage in or exclusion from the plan; the relationship between a practitioner and the administration with respect to such matters as remuneration, supplementations, location, etc.; the relationship between a group practice or any other agency and the administration; the entitlement to benefit; and so on."

Those are the type of areas where we anticipate this situation.

COMMISSIONER FIRESTONE: Could the medical profession as a whole, if it is not satisfied







Andras

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3 with the sort of answer it gets from the medical care  
4 commission as to the remuneration it is getting for  
5 the following year, appeal under that procedure?  
6 Would you envisage that as well?

7 MR. ANDRAS: I would make a distinction.  
8 I hadn't contemplated this, but since you asked me  
9 directly here, I would make a distinction between the  
10 appeals procedure that we describe here and the formal  
11 relationship between the body of professionals and the  
12 agency of the Crown that deals with the program itself.

13 THE CHAIRMAN: The appeals procedure  
14 is an individual one?

15 MR. ANDRAS: Yes.

16 COMMISSIONER McCUTCHEON: You use the  
17 word "location". Does that mean you will be telling  
18 the doctor where he is going to practise?

19 MR. ANDRAS: No, we don't suggest that.

20 COMMISSIONER McCUTCHEON: What do you  
21 mean an appeal as to remuneration, supplementations,  
22 location, etc.?

23 MR. ANDRAS: Well, we envisaged in  
24 our brief certain incentives might be offered to doctors  
25 to go to undoctored areas. We have not envisaged  
26 compulsion in that respect; we had thought that a good  
27 program would encourage doctors to locate where people  
28 could get services.

29 COMMISSIONER FIRESTONE: But coming  
30 back to the medical profession as a whole and its  
bargaining with the provincial commission, if it were  
not satisfied with the awards or no awards, what can it



with the sort of answer it gave for the nature of some  
conclusion as to the membership in the setting of  
the following very brief letter that accompanied  
would you encourage that as well?

MR. ANDERSON: I would make a distinction.

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directly here, I would make a distinction between the  
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CONFIDENTIALITY QUESTION: You use the

word "location". Does that mean you will be telling

the doctor where he is going to operate?

MR. ANDERSON: No, we don't suggest that.

CONFIDENTIALITY QUESTION: What do you

mean in appeal as to membership, and membership,

location, etc.?

MR. ANDERSON: Well, we envisaged in

our brief certain incentives might be offered to doctors

to go to indicated areas. We have not envisaged

evaluation in that respect; we had thought that a good

program would encourage doctors to locate where people

could get services.

CONFIDENTIALITY QUESTION: But could

lead to the medical profession as a whole and its

relationship with the medical community, if it were

not satisfied with the work on the scene, what could





Andras

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do or what would your plan envisage that the medical profession could do?

MR. ANDRAS: There are two or three ways it could be done. One would be through the procedure of arbitration; another could be through Board of Inquiries, which they have had in Great Britain on one or two occasions, as I understand. These are two rather obvious ones.

COMMISSIONER FIRESTONE: One point that has been made to us about the difficulties of financing a State-operated program has been the fact that such a program may have to compete for public funds with other desirable public programs. If a province or government feels that there is an urgent necessity to go ahead with the expansion of an educational program or road program, or what have you ---

COMMISSIONER McCUTCHEON: Or the C.B.C.

COMMISSIONER FIRESTONE: The problem that the medical profession would face would be that, notwithstanding the fact that there may be a growing population in the province, for this particular year there are no more funds available for medical care services. If that were the case, the medical profession would say, "We are expected to give more services and we will be getting less money for our services." They say, "We have no assurance we are going to get what the Government promised us because circumstances have changed, but we are entitled to receive it." What would be the answer to that comment that was made to us?

MR. ANDRAS: Quite candidly, I confess,





Andras

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3 when you place it in such a framework, there is no  
4 answer. It is conceivable that such a thing could  
5 occur. I would say that health care enjoys a very  
6 high priority in our set of values in our society.  
7 I doubt that once the program is embarked upon there  
8 would be such a kind of calculation or that such a  
9 calculation would result in the reduction in the  
10 degree of service or in the amounts allocated.

11 There is this aspect of the question  
12 of choice. If the program calls, say, for the construc-  
13 tion of hospitals, to use an obvious example, it is  
14 possible to change the tempo of hospital construction.  
15 This kind of thing may happen. I understand that one  
16 of the criticisms of the British scheme is that they  
17 haven't built enough new hospitals.

18 THE CHAIRMAN: They postponed the  
19 whole hospital program for a 10-year or 12-year period  
20 pretty well.

21 MR. ANDRAS: I think they have built  
22 very few hospitals, as far as I can make out.

23 COMMISSIONER McCUTCHEON: Under the  
24 hospital plan they have said, "You operate on last  
25 year's budget plus X percent" or "You operate on last  
26 year's budget." These things happen, Mr. Andras.

27 COMMISSIONER BALTZAN: Mr. Andras,  
28 such a thing you are speaking of right now has occurred  
29 in respect to the dissatisfaction on the part of the  
30 providers and the utilizers of the service you are  
speaking of. For instance, in connection with hospitaliza-  
tion, those who receive benefits, old-age benefits,





When you face it in such a way, there is no  
answer. It is some value that you would  
accept. I would say that really, some extent, a very  
high priority in our set of values in our society.  
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values on such a kind of calculation or that such a  
calculation would result in the reduction in the  
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haven't built enough new hospitals.

THE CHAIRMAN: They postponed the  
whole hospital program for a 10-year or 15-year period  
pretty well.

MR. WATKINS: I think they have built

very few hospitals, as far as I can make out.

THE CHAIRMAN: That is the

hospital plan they have said, "You operate on 100  
years' worth of new patients" or "You operate on 100  
years' worth." These things happen, I think.

COMMISSIONER WILLIAMS: Yes, sir.

Such a thing you are speaking of might now be occurring  
in respect to the construction of the new hospitals  
nowhere and the utilization of the new hospitals  
nowhere. For instance, in connection with hospitaliza-  
tion, those who receive hospital care, those who



Andras

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hospitalization, in one province it was found necessary on the part of those in government to reduce the length of stay in the hospital, reduce it from 21 to, say, 14 days, which makes the recipients unhappy and those who help those recipients unhappy.

One other thing has happened. While they receive the drug benefits right along so-called free, for which they made no extra payment for those prescription drugs, now in that same area these same people no longer can get these drugs as formerly but they must now pay one-half of the cost of those drugs.

So that all the things you are speaking of in relation to this thing are not altogether hypothetical. There are existing examples of such things happening.

MR. ANDRAS: Yes, that is true. Well, in the case of the hospital here, you have mentioned older people specifically ---

COMMISSIONER BALTZAN: Well, people who come under a prepaid, comprehensive provided service.

MR. ANDRAS: I would like to get this straight, Dr. Baltzan. If you are referring to people like those along this table, if I understand the legislation, when the circumstances require it we would be hospitalized as long as we required hospital care. I think that is substantially correct.

THE CHAIRMAN: Some along this table.

MR. ANDRAS: I think you are raising a problem of a different order, if I may be so bold as



hospitalization, in one province it was found necessary  
on the part of those in government to reduce the number  
of stay in the hospital, reduce it from 10, 12, 14,  
16 days, which makes the residents very and those  
who help those residents unhappy.

The other thing has happened. While  
they receive the drug benefits right along so-called  
free, for which they made no extra payment for those  
prescription drugs, now in that same area these same  
people no longer can get these drugs as formerly but  
they must now pay one-half of the cost of these drugs.  
So that all the things you are speaking

of in relation to this thing are not altogether sym-  
metrical. There are existing examples of such things  
concerning.

MR. ALDRICH: Yes, that is true, well,  
in the case of the hospital here, you have mentioned  
other people associatively ---

COMMISSIONER HALLAM: Well, people

who come under a prepaid, comprehensive provided  
service.

MR. ALDRICH: I would like to get  
this straight, Dr. Hallam. If you are referring to  
people like those along this river, is it understood  
the legislation, when the circumstances require it

it would be institutionalized as long as we require hospital  
care, I think that is substantially correct.

MR. ALDRICH: I think that is right.

MR. ALDRICH: I think you are right.

A problem of a different order, if I may be so bold as





Andras

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to suggest. I think it is common knowledge in the case of a number of elderly people that the hospital is not so much a place for treatment as a place to keep them because there is no other place for them to stay.

THE CHAIRMAN: I am going to suggest that this is extraneous to our discussion at this moment. I will ask Dr. Baltzan to accept that.

COMMISSIONER FIRESTONE: If we can continue, Mr. Andras, on the question of financing the program. Is the answer to my question, sir, that you would rely on the good judgment of those that allocate funds to allocate them to what you consider a high priority project, and you consider health, like education, high priority programs and therefore programs that you would expect would attain the necessary funds to carry on efficiently and in an expanding scale in the light of expanding population and increasing medical technology. Is that what you had in mind?

MR. ANDRAS: I am sorry, I was diverted. Would you repeat it, please?

COMMISSIONER FIRESTONE: It is rather a long question, and I will shorten it. What I want to know is what assurance does the public and the medical profession have that adequate funds will be forthcoming under such a program?

MR. ANDRAS: I think with the universal program and with the high value attached to education in other countries you have a built-in assurance that funds will be provided as should be, by statute.



to suggest, I think it is common knowledge in the case  
of a number of elderly people that the hospital is not  
so much a place for treatment as a place to keep them  
because there is no other place for them to stay.

THE CHAIRMAN: I am going to suggest

that this be extraneous to our discussion at this  
moment. I will ask Dr. Johnson to accept that.

DR. JOHNSON: I accept that. We can

continue, Mr. Anderson, on the question of financing  
the program. As the answer to my question, sir, that

you would rely on the good judgment of those that  
allocate funds to allocate them to what you consider  
a high priority project, and you consider health,

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expanding scale in the light of expanding population  
and increasing medical technology. Is that what you

had in mind?

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diverted, would you repeat it, please?

THE CHAIRMAN: I repeat it. It is your

long question, and I will shorten it. What I want

to know is what assurance does the public and the

medical profession have that adequate funds will be

forthcoming under such a program?

MR. ANDERSON: I think that the insurance

companies and with the high value attached to education in

other countries you have a built-in assurance that

funds will be available and should be, by statute.



Andras

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4 I could carry the answer a little  
5 further and say this, that where you have an earmarked  
6 contribution for that service, then the assurance is  
7 even greater because you have a trust fund which is  
8 used for that purpose. In Saskatchewan, for example,  
9 it is not an exclusive mode of financing, and to that  
10 extent the latter part of my answer falls short.

11 COMMISSIONER FIRESTONE: You would  
12 feel that whatever revenues are collected to pay for  
13 such a medical care program should be earmarked for  
14 this purpose?

15 MR. ANDRAS: Well, if they are an  
16 earmarked tax, yes; premium, I mean.

17 COMMISSIONER FIRESTONE: Some of it  
18 may be used for education, some for other essential  
19 purposes. Would you say that that province should  
20 earmark X percent for that purpose? Would you feel  
21 that there would be greater assurance? There was the  
22 333 formula that was used.

23 MR. ANDRAS: Yes.

24 COMMISSIONER FIRESTONE: Sometimes it  
25 is adequately financed and sometimes it isn't.

26 MR. ANDRAS: I have never considered  
27 the 333 as a structure for funds. I have simply taken  
28 it as a form of taxation. I have assumed that if  
29 anybody is entitled to benefit he is going to get it.  
30 So the device of saying that 333 is a method of payment  
doesn't create the fund. Perhaps the analogy is not  
right. Your question really is, should we have an  
earmarked fund or should we not?





I could carry the answer a little

further and say this, that where you have an arrangement  
contribution for that service, then the assurance is  
even greater because you have a trust fund which is  
used for that purpose. In Saskatchewan, for example,  
it is not an exclusive mode of financing, and to that  
extent the latter part of my answer falls short.

COMMISSIONER TIERNEY: You would  
feel that whatever revenues are collected to pay for  
such a medical care program should be earmarked for  
this purpose?

MR. ANDRAE: Well, if they are an  
earmarked tax, yes; otherwise, I mean.

COMMISSIONER TIERNEY: Some of it  
may be used for education, some for other essential  
purposes. Would you say that that province should  
contribute 5 percent for that purpose? Would you feel  
that there would be greater advantages? There was the  
3-3 formula that was used.

MR. ANDRAE: Yes.

COMMISSIONER TIERNEY: Another is  
a 50-50 plan and sometimes it is 1-1.

MR. ANDRAE: I have even considered  
the 3-3 as a structure for funds. I have actually taken  
it as a form of taxation. I have assumed that it  
should be applied to benefits as it goes to the  
to the device of saying that it is a method of payment  
doesn't come to the fund. Perhaps the only way is not  
that. Your question really is, should we have a  
method of fund on which we put?



Andras

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COMMISSIONER FIRESTONE: Yes.

MR. ANDRAS: Well, our preference is not for these forms of financing. We recognize, however, that the provinces have embarked on certain patterns, as in the case of hospital care, and it is quite likely they will continue the same patterns, in which case we think there should be safeguards against tendency to create hardship.

COMMISSIONER FIRESTONE: But where such funds are collected on the basis of what you describe, should they, in your opinion, be earmarked for medical care purposes?

MR. ANDRAS: If they are earmarked for that purpose, then that is the charge, only charge, I would say, on such funds.

COMMISSIONER FIRESTONE: Then you would support such an arrangement?

MR. ANDRAS: No, we wouldn't. We would like an arrangement without earmarked funds, but if they are earmarked funds, then obviously they should belong to that particular purpose.



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PM/hm

Andras

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4 COMMISSIONER FIRESTONE: All right,  
5 if there are no earmarked funds, the ideal solution is  
6 achieved that you have in mind, how do you achieve the  
7 objective to make sure that the fund will be adequate  
8 to pay doctor bills or other health costs?

9 MR. ANDRAS: Well, through orderly  
10 budgeting and similar arrangements on the part of the  
11 government. Perhaps Dr. Forsey has something to say.

12 DR. FORSEY: I think you answered that  
13 before. I just said to Mr. Goldberg "Now we are back  
14 where we started from".

15 COMMISSIONER FIRESTONE: That is quite  
16 correct because I wanted to see what assurances can be  
17 given to those who are apprehensive of not being able  
18 to get the sort of funds that will be required. This  
19 point has been made to us and if you say you rely on the  
20 high priority which the Canadian public gives to it then  
21 say so or if you have some other answer please say what  
22 it is.

23 DR. FORSEY: You did say so, did you  
24 not? I thought you had but perhaps my deafness is worse  
25 than I thought it was. I think that is exactly what Mr.  
26 Andras said.

27 COMMISSIONER FIRESTONE: If that is  
28 what he meant to say then that is the answer.

29 DR. FORSEY: I would only quote George  
30 Meredith when he said: "Oh what a dusty answer gets  
the soul when hot for certainty in this our life." I  
do not think you can get 100% assurance on this thing,  
I think it is asking for the impossible. You can only



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COMMISSIONER FIRSTMAN: That is quite correct because I wanted to see what assurance can be given to those who are apprehensive of not being able to get the sort of funds that will be required. This point has been made to us and it you say you rely on the high priority which the Canadian public gives to it then say so or if you have some other answer please say what it is.

DR. FORSEY: You did say so, did you not? I thought you had but perhaps my deafness is worse than I thought it was. I think that is exactly what Mr.

COMMISSIONER FIRSTMAN: If that is what he meant to say then that is the answer.

DR. FORSEY: I would only quote George Meadell when he said: "Oh what a costly answer gets the soul when not for certainty in this our life." I do not think you can get 100% assurance on this thing, I think it is asking for the impossible. You can only



Andras

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4 get a reasonable degree of assurance and you have to  
5 rely to a considerable extent on what Mr. Robert Borden  
6 always called the exercise of the commonplace quality  
7 of common sense. I think the legislators in this  
8 country on the whole possess a reasonable degree of  
9 a commonplace quality of common sense and will probably  
10 exercise it.

11 COMMISSIONER FIRESTONE: I am very  
12 much obliged for this extended answer. Mr. Andras, on  
13 this question of financing and payment, as I understand  
14 it your principal recommendation is to pay the medical  
15 profession on a salary basis or your preferred method  
16 of payment. I think you also say that you can visualize  
17 to such a system to be added an incentive method of  
18 payment; what for would you feel such an incentive  
19 payment would take?

20 MR. ANDRAS: We suggested in our brief  
21 that it could take the form of supplementation by fee  
22 for service or capitation. I cannot give you the specific  
23 paragraph from memory.

24 COMMISSIONER FIRESTONE: Paragraph 117  
25 and paragraph 159. In paragraph 159 you say:

26 "The salary system should be considered  
27 "as a basic means for remuneration,  
28 "subject to supplemenation by some  
29 "other means."

30 That is on page 64. I am trying to  
visualize what kind of incentive you have in mind, what  
do you say to the doctor? You say "Your basic salary is  
X dollars and if you do such and such you will get extra





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COMMISSIONER FLEETON: I am very

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 to such a system to be added an incentive method or  
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 payment could take?

MR. ANDERSON: We suggested in our brief

that it could take the form of supplementation by fee  
 for service on callation. I cannot give you the specific  
 paragraph from memory.

and paragraph 12. In paragraph 12 you say:

"The salary system should be considered

as a basis for remuneration,

"subject to remuneration in case

"other means."

"That is on page 14. I am trying to

visualize what kind of incentive you have in mind, what  
 do you say to the doctor? You say "Your basic salary is  
 \$10,000 and if you do such and such you will get extra



Andras

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3 pay"? What is this such and such?

4 THE CHAIRMAN: No, if you go to such  
5 and such a place you will get extra pay. These are,  
6 I would think, administrative matters.

7 MR. ANDRAS: And extremely complex  
8 ones. We have not suggested, and I hope it was not read  
9 into our brief that we would contemplate a flat salary for  
10 all physicians in Canada; this would horrify us as much  
11 as it would you.

12 COMMISSIONER McCUTCHEON: You have  
13 answered it on page 63 where you say:

14 "Accordingly, we consider that considera-  
15 tion might be given to some form of  
16 "supplementation either through  
17 "capitation or fee for service."  
18 Maybe there are other means.

19 COMMISSIONER FIRESTONE: My question  
20 was not relating to the method because that you have  
21 answered. I just wonder under what circumstances would  
22 you offer such additional pay?

23 MR. ANDRAS: It may be related to the  
24 number of patients, the location of the physician to the  
25 nature, the breakdown of the patients. Supposing a  
26 physician had a very high proportion of elderly patients  
27 where the incidence of illness was greater than a group  
28 say from 21 to 35 years of age so his work was that much  
29 more considerable, then this would be cause, in our  
30 opinion, for revision of this structure of payment.

31 COMMISSIONER FIRESTONE: May I now  
32 turn to paragraph 51 on page 25 where you deal with the



pay? What is to be paid and when?

THE CHAIRMAN: No, if you go to such

and such a place you will not extra pay. These are,

I would think, administrative matters.

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into our brief that we would contemplate a flat salary for

all physicians in Canada; this would normally be as much

as it would you.

COMMISSIONER HENDERSON: You have

answered it on page 33 where you say:

"Accordingly, we consider that consid-

"tion might be given to some form of

"supplementation either through

"capitation or fee for service."

Maybe there are other means.

COMMISSIONER FISHBONE: In question

was not related to the method because that you have

answered. I just wonder under what circumstances would

you offer such additional pay?

MR. AMBROS: It may be related to the

number of patients, the location of the physician to the

nature, the frequency of the patients. Supposing a

physician had a very high proportion of elderly patients

where the incidence of illness was greater than a group

say from 61 to 65 years of age so his work was that much

more considerable, then this would be a case, in our

opinion, for revision of the structure of payment.

COMMISSIONER FISHBONE: When you say I don't

turn to paragraph 11 on page 33 where you deal with the





Andras

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4 means test requirements and also to the second paragraph  
5 on page 4 of the statement that Mr. Jodoin presented  
6 this morning in which you deal with means tests. I  
7 take it from what you say both in the brief and the  
8 supplementary statement we heard this morning that you  
9 are opposed to such a procedure and I find in the second  
10 paragraph on page 4 a qualification of that approach  
11 where you say you are opposed to the large scale extension.  
12 Then you say such tests should be merely peripheral to  
13 the main body. Are there situations under which you  
14 are prepared to accept the means test?

15 MR. ANDRAS: In terms of social  
16 security, in the broad term of social security we  
17 recognize that a good social security structure must  
18 provide an element of a needs or means test or some  
19 such test. If you have, and this is really more applicable  
20 where you have a flat rate benefit system based on  
21 average need, no matter how adequate that rate might be  
22 there will be circumstances involving certain people  
23 who must go beyond the benefit division where there will  
24 be evidence of need and to that extent we subscribe to  
25 the means test or needs test, whichever term you happen  
26 to prefer. We realize in a program where there is a  
27 premium payment, Saskatchewan, Ontario, I think Manitoba,  
28 where you have a premium, the absolute amount of the  
29 premium will determine the extent of the application of  
30 a means test; the larger your premium payment the more  
people fall into the need, the smaller the fewer. What  
we are trying to do is recognize what exists if there  
are three or four provinces in Canada with a premium type



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we are trying to do is recognize what exists: if there  
are three or four provinces in Canada with a premium type



Andras

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4 of payment; what we are saying is we recognize this will  
5 produce a means test situation. We think at the very  
6 least extensive application should be guarded against  
7 but basically we object to the term which would by its  
8 very nature impose a means test on a considerable portion  
9 of the population and that is what we read into several  
10 of the submission that have come before you.

11 COMMISSIONER FIRESTONE: If I understand  
12 you correctly, you are objecting to a means test in  
13 principle but if this principle has to be applied in  
14 a few provinces on a moderate scale you are prepared  
15 to put up with it.

16 MR. ANDRAS: I would say we do not  
17 like to put up with it, if we have no alternative we  
18 will. We are law-abiding citizens. Let me put it in  
19 these terms; yesterday before coming out here I looked  
20 very hurriedly at one or two of the briefs put in by  
21 the medical societies, one actually and this was the  
22 British Columbia brief. It happens they sent me a copy  
23 of the brief and if I read it correctly, and I do not  
24 want to say anything that is unfair, I rather like to  
25 have a good relationship with the medical profession,  
26 but I read into the brief an assumption on their part  
27 that their proposal would mean the application of a means  
28 test to 11.1% of the households of that province over  
29 and above those already on social assistance medical  
30 service. In my book this is an extraordinarily large  
number of people to whom to apply a means test and we  
would not willingly condone it.

THE CHAIRMAN: Might you not read it





of patients that we are giving is we recognize that this  
process is a means test situation. We think at the very  
least an active application should be demanded against  
it. Actually we object to the term which would by its  
very nature impose a means test on a considerable portion  
of the population and that is what we want to avoid.  
of the suggestion that have some better way.

DR. LESTER W. BROWN: If I understand  
you correctly, you are objecting to a means test  
because but if this principle has to be applied in  
a few cases on a moderate scale you are prepared  
to put up with it.

DR. W. BROWN: I would say we do not  
like to put up with it, if we have no alternative we  
will. We are law-abiding citizens. Let me say it in  
three terms; yesterday before coming out here I read  
very hurriedly at one or two of the books but in my  
the medical societies, one actually met and read the  
British Columbia paper. It happens they read the copy  
of the book and if I read it correctly, and I do not  
want to say anything that is unfair, I would like to  
have a good relationship with the medical profession,  
but I read it to the effect of reservation on their part  
that their proposal would mean the application of a means  
test to 11.1% of the households of that province over  
and above those already on social assistance medical  
aid. In my book this is an extreme, actually I hope  
hundreds of people to whom to apply a means test and we  
would not willingly impose it.  
DR. W. BROWN: I would say we do not



Andras

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4 another way to say that the medical profession wished  
5 to exempt from payment of premiums an additional 11%  
6 of the households of British Columbia?

7 MR. ANDRAS: No sir, I do not want to  
8 put it that way.

9 COMMISSIONER McCUTCHEON: Just one  
10 point: You did not say that you were opposed to a means  
11 test in principle in the whole particular area of social  
12 security?

13 MR. ANDRAS: That is right.

14 COMMISSIONER McCUTCHEON: I take it  
15 from what Mr. Jodoin said this morning that you recognize  
16 the necessity of the means test in a certain type of  
17 social security program. I think you said that earlier.  
18 You did not say categorically "I am opposed to a means  
19 test"?

20 MR. ANDRAS: No, sir.

21 COMMISSIONER FIRESTONE: On this point  
22 I perhaps did not understand you quite correctly. Are  
23 you in favour of the principle of a means test?

24 MR. ANDRAS: What I tried to say  
25 before in the framework in a social security system of  
26 a country or a province, if that system is to be an  
27 adequate system then it will have to include an element  
28 of means test to satisfy the needs of people whose  
29 needs are beyond what is considered the average need.

30 COMMISSIONER FIRESTONE: Could we  
confine this to the subject before us and that is the  
field of health care services. Are you in favour of the  
principle of a means test in providing a program of



...to say that the medical profession ...  
...to a certain extent of ...  
...of the ...

MR. ANKAS: Yes, sir, I ...

...that way.

...that ...

...point: You did not say that you were ...  
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...field of health care services. ...  
...principle of a means test in providing a program of





Andras

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3 health care service for the Canadian people?

4 MR. ANDRAS: No, sir.

5 THE CHAIRMAN: I am just going to give  
6 you another chance to disagree. You say that the  
7 Province of Saskatchewan is on the wrong track in  
8 proposing a means test in connection with the collection  
9 of the premium?

10 MR. ANDRAS: We appeared before the  
11 Advisory Planning Committee on Medical Care and we  
12 submitted a brief and we said to them that we considered  
13 a premium form of payment is regressive and creates a  
14 need for means tests. To that extent we disagreed with  
the province.

15 COMMISSIONER FIRESTONE: May I now  
16 turn to page 79, paragraph 186 where you make some  
17 reference to a method of prepayment of drugs and you  
18 say, as I understand it, in this paragraph and in an  
19 earlier paragraph that you are in favour of a compre-  
20 hensive health care program to include prepayment on  
drugs?

21 MR. ANDRAS: Provision of drugs.

22 COMMISSIONER FIRESTONE: The provision  
23 of prescribed drugs?

24 MR. ANDRAS: That is right, yes.

25 COMMISSIONER FIRESTONE: Now, in this  
26 paragraph 186 you deal with some methods of keeping the  
27 cost of drugs down. Am I right in interpreting some  
28 of the comments which you make in the latter part of the  
paragraph to be designed to achieve that objective?

29 MR. ANDRAS: To effect an economy in  
30



health care service for the Canadian people?

MR. ANDRAE: No, sir.

THE CHAIRMAN: I am just going to give

you another chance to disagree. You say that the

province of Saskatchewan is on the wrong track in

proposing a means test in connection with the collection

of the premiums?

MR. ANDRAE: We appeared before the

Advisory Planning Committee on Medical Care and we

submitted a brief and we said to them that we considered

a premium form of payment is regressive and creates a

need for means tests. To that extent we disagreed with

the province.

COMMISSIONER FIRESTONE: May I now

turn to page 79, paragraph 186 where you make some

reference to a method of prepayment of drugs and you

say, as I understand it, in this paragraph and in an

earlier paragraph that you are in favour of a com-

prehensive health care program to include prepayment on

MR. ANDRAE: Provision of drugs.

of prescribed drugs?

MR. ANDRAE: That is right, yes.

COMMISSIONER FIRESTONE: Now, in this

paragraph 186 you deal with some methods of meeting the

cost of drugs down. Am I right in interpreting some

of the comments which you make in the latter part of the

paragraph to be designed to achieve that objective?

MR. ANDRAE: To effect an economy in



Andras

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3 the use or the purchase of drugs.

4 COMMISSIONER FIRESTONE: And as a  
5 result of the economy you would hope that drug prices  
6 could be reduced, is that your objective?  
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MEMORANDUM FOR THE SECRETARY OF DEFENSE

the use of the process of defense.

CONSTITUTIONAL RIGHTS: And as a

result of the economy you would hope that other prices

would be reduced, as that your objectives

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4 MR. ANDRAS: Costs of that aspect of  
5 the program could be reduced.

6 COMMISSIONER FIRESTONE: Could be  
7 reduced. Now, sir, some of the suggestions are  
8 purchases of drugs through their generic titles and on  
9 the wholesale and on a bulk basis. The suggestion  
10 has been made to us that we should produce more drugs  
11 in Canada, there should be more drugs manufactured in  
12 Canada. Several reasons were given for that including  
13 one, more employment as a result of expanding the drug  
14 industry in Canada. There were other reasons, national  
15 defence and so on. If such proposals were implemented  
16 to develop ways and means to encourage more drugs to  
17 be manufactured in Canada, we would be facing, perhaps a  
18 problem as far as the costs of drugs are concerned  
19 because many of the drugs imported to Canada  
20 are lower priced drugs than we could manufacture given  
21 a smaller size market. Are we not facing here a dilemma,  
22 and what are your views on this dilemma? On the one  
23 hand give encouragement to expanding the manufacture,  
24 more employment for Canadians but the importation of  
25 drugs from abroad means lower prices to the consumer.  
26 What is the answer to the dilemma?

27 MR. ANDRAS: I would suggest with  
28 much respect that is really extraneous to the issue  
29 before us; this is a matter of Government policy, for  
30 a Government to implement.

THE CHAIRMAN: I think we have enough,  
a big enough problem without going into tariff, etcetera.

MR. ANDRAS: Thank you very much.







Andras 11331

COMMISSIONER FIRESTONE: Are you in favour of lower priced drugs in Canada?

THE CHAIRMAN: I don't think that is a fair question to put in this context.

COMMISSIONER McCUTCHEON: Mr. Andras is obviously against sin in any form.

COMMISSIONER FIRESTONE: I think Mr. Andras can answer for himself.

MR. ANDRAS: You mean on the question of sin?

COMMISSIONER FIRESTONE: On the question of drug prices.

MR. ANDRAS: Quite obviously we want drug prices to be lower if we can get them and maintain the quality of the drugs. As to whether they should be produced here or abroad and what the policy should be, this is not entirely relevant to the question of a public health program.

COMMISSIONER FIRESTONE: You have answered my question in the sense you say your principal priority is lower drug prices for Canada.

MR. ANDRAS: The principal priority is to have drugs, to have drugs available to those who need them and the program as a whole including the drug segment should be economic and efficiently administered.

COMMISSIONER FIRESTONE: Thank you very much, Mr. Jodoin, Mr. Andras and gentlemen. You have been very helpful and patient with the questions.

THE CHAIRMAN: Dr. Baltzan, you have been very busy writing there.



Q. Now, is it not true that the

favor of lower prices drugs in Canada?

A. Yes, I don't think there is

a fair question to put in this context.

is obviously against him in my town.

COMMISSIONER: I think so.

He has an answer for himself.

MR. WATSON: You mean on the question

of this question? On the question

of drug prices.

MR. WATSON: Quite obviously we want

drug prices to be lower if we can get them and maintain

the quality of the drugs. As to whether they should be

produced here or abroad and what the policy should be, this

is not entirely relevant to the question of a public health

program.

answered my question in the sense you say your principal

priority is lower drug prices for Canada.

MR. WATSON: The principal priority is

to have drugs, to have drugs available to those who need

them and the program as a whole including the drug

segment which is economic and is efficiently administered.

Q. Now, is it not true that the

very low, Mr. Watson, Mr. Watson and Commissioner. You

have been very helpful and patient with the questions.

THE CHAIRMAN: Mr. Watson, you have

been very helpful and patient.



Andras 11332

COMMISSIONER BALTZAN: Taking notes.

I have no questions, but I would like to make this comment, that I have listened with very great interest and very close attention and I hope we will be able to blend all interests presented by all who have appeared before us into one happy Canadian solution.

MR. ANDRAS: Be sure you blend, do not mix.

COMMISSIONER BALTZAN: That is why I chose the word "blend".

THE CHAIRMAN: Dr. Van Wart.

COMMISSIONER VAN WART: Mr. Andras, the Canadian Federation of Agriculture when it appeared before us and submitted their brief, in essence their brief advocated the same type of system which you are advocating. They said they previously had submitted similar briefs some years before and had advocated no premiums, but in the brief they presented to us they advocated a premium, somehow in conjunction with this plan. Would you elaborate a little on why not? You have given us two reasons already that you are opposing the premium.

MR. ANDRAS: We are opposed to it on two grounds. One it takes the nature of a regressive thing since they are different for a single person and family. It bears no relationship, no direct and obvious relation to income. The second is by the very nature of your market and the control upon the people in the community therefore, they have given the service on the basis of a means test which we have been objecting to,





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MEMORANDUM

I have no questions, but I would like to make this comment that I have listened with very great interest and very close attention and I hope will be able to blend all interests presented by all who have appeared before us into one happy Canadian solution.

Mr. Adams: Be very, very kind, do

COMMISSIONER BAILLIARD: That is why

I chose the word "blend".

Mr. Adams:

The Canadian Federation of Agriculture when it appeared before us and submitted this brief, in essence that brief had stated the same type of action which you are advocating. They said they had already had submitted similar briefs some years before and had advocated no problems, but in the brief they requested to us that we advocated a program, somehow in connection with this plan. Would you elaborate a little on this point? You have given us two reasons which are not very opposing the program.

Mr. Adams: We are opposed to it on

two points. One it takes the nature of a cooperative plan since they are in fact for a single group of individuals. It seems to me extremely important and of great value to farmers. The second is the very nature of your request for the kind of plan in the country. The plan is a plan for the service of the basis of a means to the farmer and to the public.



Andras 11333

particularly within the framework of what we propose here.

COMMISSIONER VAN WART: You have given those two reasons before. Were there any other reasons why you oppose this?

MR. ANDRAS: In some places there is a serious administration problem. The British Columbia Hospital Plan pretty well foundered in its first few years because with the capitation and premium system they didn't collect from enough people and people appeared at the hospitals without evidence of paying and they had to admit them if they were referred to the hospital. They had to get in. Then they put in the sales tax system and I gather it has worked quite well. I haven't heard it hasn't.

In Saskatchewan you have a different distribution of population, far less concentration in the city centres and the administrative structure of collection is efficient. I gather it is done through the local townships. They have had no problem and the farmers are quite accustomed to it and it works well. Furthermore, Dr. Van Wart, in a large population relatively homogeneous in occupation and income, in outlook and so on, the premium payment would not have, would not present the same problems as it would in places like Montreal where you have wide ranges of income, of outlook and so on, and of course, accessibility of the people themselves. The mobility of Montreal is a problem in that connection.

COMMISSIONER VAN WART: There is one other question I wish to ask: Under your plan would you



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Andras 11334

retain the voluntary agencies such as the Heart Foundation and the Cancer Association and so on?

MR. ANDRAS: Yes, but their function is rather different from what we consider as a service function in our plan. They engage in educational work which is preventive in itself and they do research. They serve a very useful purpose in that respect. The problem with the health agencies is not they are not being useful. Some of them. The problem is there seems to be no rational arrangement between the agencies in terms of some priorities of necessities, which should get more, should the Heart Foundation get more than the Cancer or should the Muscular Dystrophy get more or get less and so on and so forth. This is the problem that will have to be solved because it has become more severe as time goes on. The voluntary agencies will have a useful function in the field of education and prevention.

COMMISSIONER VAN WART: The last question on Page 48, Section 126: "We are advocates of group practice of medicine because we have become convinced that through it the doctor can do his best work on behalf of his patient". Do you have any type of group practice in mind, group practice such as H.I.P. in New York or the loosely-knit group practice we have here.

MR. ANDRAS: There are a number of group practices, H.I.P., Kaiser Permanente is another, the one in Seattle, one in Minnesota, St. Louis, Missouri, our Community Health Association in Detroit -- you have enormous, that is a large word, you have a considerable number of very reputable organizations of the sort which



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...the voluntary agencies such as the Heart Foundation  
and the Cancer Association and so on.  
...the Heart Foundation and the Cancer Association  
is rather different from that of the other  
...in our country. They are in a national work  
which is preventive in the sense of research. They  
serve a very useful purpose in that respect. The problem  
with the health agencies is not only that they are not being useful  
...of them. The problem is more severe than in no nation  
...between the agencies in the sense of the  
priorities of necessities, which should get more, should  
the Heart Foundation get more than the Cancer Association  
the "National Cancer Society" get more or not less than the  
as health. The problem that will have to be  
...more severe as time goes on.  
The voluntary agencies will have a certain function in  
the field of education and prevention.  
...the year  
...on the "National Cancer Society" as are concerned with  
the practice of medicine because we have become convinced  
that through the doctor and the hospital, and in health  
of the nation. The voluntary agencies are not a group of  
in which. They are in the sense of the  
to all - this group, and we have here  
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...the voluntary agencies in the sense of the  
...in a large way, and we have a considerable  
...of very notable effect in the sense of the



Andras 11335

produce, by all accounts, high-quality of care because of the benefits of cooperation within the medical field by the practitioners.

COMMISSIONER VAN WART: Are those feasible or practical to the Canadian situation?

MR. ANDRAS: Well, we think so. I think there is one coming up in the near future at Saulte.

THE CHAIRMAN: In Sault you have a different situation. That is the industry looking after all the health services.

MR. ANDRAS: It will be a community institution.

MR. GOLDBERG: Initially it will be started by an organization initiated through the efforts of the trade unions involved in Sault Ste. Marie.

THE CHAIRMAN: It will be a closed panel.

MR. GOLDBERG: Ultimately we hope to have this serve the whole community and be community-sponsored and community based.

THE CHAIRMAN: For the moment it is a closed panel arrangement in which the medical people and others will be on a salary basis?

MR. GOLDBERG: Yes.

THE CHAIRMAN: And the H.I.P., the Kaiser Permanente, these are all on a premium basis, are they not?

MR. ANDRAS: Actually the one in Seattle is a cooperative based on the Rushdale principles





of the benefits of cooperation within the medical field  
by the practitioners.

COMMITTEE: I think we have those

possible or practical to the Canadian situation.

MR. LAMONTAGNE: Well, we think so, I

think there is one coming up in the near future at

Calgary.

THE CHAIRMAN: In 1961 you have a

different situation. That is the situation looking after

all the health services.

MR. LAMONTAGNE: It will be a community

interest one.

MR. LAMONTAGNE: Initially it will be

started by an organization initiated through the efforts

of the three universities in 1961, I think.

THE CHAIRMAN: It will be a closed

panel.

MR. LAMONTAGNE: Initially we have to

have this serve the whole community and be community-

oriented and community based.

THE CHAIRMAN: For the moment it is a

closed panel arrangement in which the panel people and

others will be on a very local

level. And the 1961, the

initially, there will be a panel of people in it, and

then

MR. LAMONTAGNE: I think in the

beginning is a closed panel on the local level.



Andras : 11336

of cooperation, if I understand it correctly. They have shareholder interests. I think the shares are \$100.00 and there is a premium payment as well.

THE CHAIRMAN: They also have a drug component on a purely cooperative basis in the same area.

MR. GOLDBERG: In this regard, Mr. Chairman, there is really no basic difference between the program that is organized in Sault Ste. Marie and those in existence in the United States. The program will be financed through a certain amount of contribution going to the program. In Sault Ste. Marie it is through negotiations with the employer or employers.

THE CHAIRMAN: Except they haven't their own hospital to which other doctors who don't belong to the plan cannot go.

MR. ANDRAS: Where is that, sir?

THE CHAIRMAN: In many of the American ones, for instance the one in St. Louis.

MR. ANDRAS: Some have their own hospitals and some do not.

THE CHAIRMAN: The one in St. Louis, that is the way it is based, if I understand it.

MR. ANDRAS: In St. Louis the Labour Health Institute in St. Louis doesn't have its own hospital. It uses the community hospitals. The plan in Seattle, the Group Health Cooperative of Puget Sound does have its own hospital.

THE CHAIRMAN: And Kaiser Permanente does.



of cooperation, if I understood it correctly, they have  
transferred interests, I think the shares are \$100,000  
and there is a provision payment as well.

THE CHAIRMAN: They also have a right

to receive as a family cooperative basis in the same  
area.

MR. CHAIRMAN: Is that correct?

THE CHAIRMAN: There is really no basis for the plan in the  
program that is organized in the area, and those  
in existence in the United States. The program will be  
financed through a certain amount of contribution going  
to the program. In fact, the plan is to be  
negotiations with the employer's interests.

THE CHAIRMAN: Except they have

their own hospital to which other doctors would  
belong, to the plan cannot be

MR. CHAIRMAN: Where is that, sir?

THE CHAIRMAN: In many of the American

ones, for instance the one in St. Louis.

MR. CHAIRMAN: Is that correct?

Hospitals and some do not.

THE CHAIRMAN: The one in St. Louis.

That is the way it is based, is it correct?

MR. CHAIRMAN: In St. Louis is a major

health institution in St. Louis doesn't have the two

hospitals. It has the primary hospital, the plan in  
fact, the other health organizations in fact do not  
have the own hospital.

THE CHAIRMAN: The hospital is





Andras 11337

MR. ANDRAS: H.I.P. doesn't. Yes.

There are a variety of programs, the principles of which are established pretty similarly throughout all the group practice plans in the United States.

THE CHAIRMAN: They are all on a premium basis.

MR. ANDRAS: Yes, income basis. Premium basis is a sort of peculiar way of expressing it. For example, the United Mine Workers program is financed from contributions paid to their Social Security program, part of which goes to provide medical care services. The program itself, the group practice programs receive income on a number of different bases, but there is no real dissimilarity on that ground.

THE CHAIRMAN: Gentlemen, we are very grateful to you and we could have carried on this discussion for much longer, because it isn't so often a group such as ours may have the opportunity of such discussion on such an intelligent basis and such preparation as that with which you have come to us this morning. We are grateful to you for the presentation of the submission itself and for your good nature in dealing with the questions.

Mr. Anderson: Yes.

There are a variety of programs, the objectives of which are established by the community and the group practice plans in the future.

THE CHAIRMAN: There are all on a

premium basis.

Mr. Anderson: Yes, there is a premium basis.

There is a sort of room that is of experience, for example, the United States Workers program is financed from contributions paid to the United States Workers, part of which goes to providing medical and dental care. The program itself, the group practice program is financed on a number of different bases, but there is no real distinction on the group.

The Chairman: Yes, there is.

Very grateful to you and we can't have a meeting on this discussion for much longer, because it is a discussion a group such as ours has had. The discussion on such an initial basis is a very important one as it is with which you are going to be able to help. It is a question to you for the presentation of the

the program.



Jodoin

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4 MR. JODOIN: Mr. Chairman, Mademoiselle  
5 Girard, and members of the Royal Commission on Health  
6 Services: first of all, I would like to express my  
7 thanks to the Lord this morning for having provided  
8 us with air conditioning, which, as far as I am  
concerned, has some kind of a priority.

9  
10 Secondly, to you, sir, and ladies  
11 and gentlemen of the Commission for the time you have  
12 given us and the interest shown in the submission made  
13 by us. I would say just in passing to Dr. Firestone  
14 that he is an excellent negotiator, and one of these  
15 days I hope he will be on this side of the table.

16  
17 I would just like to say on the main  
18 subject matter on which he questioned us that as far  
19 as budgetary provision by government authority for  
20 the implementation of health services, the medical  
21 profession, for whom I have all the respect in the  
22 world I assure you, have better guarantees than we  
23 have in certain industry for employment. I just have  
24 to mention a few quickly, Avro, Elliot Lake and many  
25 others, where much employment has disappeared, whereas  
26 in this case it never will, and the duty, and the  
27 dedication of the profession itself is a must as far  
28 as the human being is concerned, and certainly would  
29 deserve all consideration to the extent that we have  
30 discussed it because of the qualifications.

31  
32 You know, Your Honour, when I was  
33 young, if I may say so, in the days of the depression,  
34 I had an ambition. My ambition was to become a surgeon.  
35 Maybe it is good for the patients or the patients that





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Mr. Chairman, I am pleased to be here.

First, and members of the Commission on Health Services, first of all, I would like to express my thanks to the staff for having provided us with this information, which, as far as I am concerned, has some kind of a priority.

Secondly, to you, sir, and ladies.

and gentlemen of the Commission for the time you have given us and the interest shown in the information made by us. I would say just in passing to Dr. Firestone that he is an excellent negotiator, and one of these days I hope he will be on this side of the table.

I would just like to say on the main

subject matter on which he questioned us that as far as the provision of health services, the medical profession, for whom I have all the respect in the world I assure you, have better paid rates than we have in certain industry for employment. I just have to mention a few quickly, Avco, Union Carbide and many others, whose main employment was in the medical field. In this case it never will, and the day, and the dedication of the profession itself is a great deal more than the human being is concerned, and certainly with some of the consideration to the extent that we have discussed it because of the public interest.

Now, if I may say so, in the case of the profession, I had an impression. My impression was to have a somewhat more of a lot for the patients and the patients that



Jodoin

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I would have had, that I didn't succeed, because of the profession itself ---

COMMISSIONER McCUTCHEON: Then you would have been on the opposite side of the table.

MR. JODOIN: Of course, I am satisfied today, and my colleagues too, because we are trying to practise surgery in our social and economic legislation.

But having said this, we know of the importance of the subject matter. That is why I must admit that the brief was rather long. I am grateful to see that you did study it, which certainly is agreeable to us. I only certainly hope that it will be taken in due consideration in the interests of the people of Canada, and I thank you for your hearing.

THE CHAIRMAN: Yes, I mean a Commission such as this would not fail to take into consideration a submission which comes from such a large group of Canadian citizens.

MR. JODOIN: Well, I am sure, Your Honour, that you don't mind that. I mentioned it because we really appreciate it.

THE CHAIRMAN: Oh no.

--- Short Recess



I would have had, that I didn't expect, because of

the situation itself ---

COMMISSIONER: Then you

would have been on the opposite side of the table.

MR. JORDAN: Of course, I am satisfied

today, and my colleagues too, because we are trying

to practise surgery in our social and economic legisla-  
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a submission which comes from such a large group of

Canadian citizens.

MR. JORDAN: Well, I am sure, now

honour, that you don't mind that. I mentioned it

because we really appreciate it.

THE CHAIRMAN: Oh no.

--- about 1950





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THE CHAIRMAN: Now, ladies and gentlemen, if we may come to order we will proceed.

THE SECRETARY: Mr. Chairman, the next submission is from the Toronto and District Ex-Servicemen's Advisory Committee. Mr. Varley will present the submission, and it will be known as Exhibit No. 320.

--- EXHIBIT NO. 320: Submission of the Toronto and District Ex-Servicemen's Advisory Committee.

SUBMISSION OF THE TORONTO AND DISTRICT  
EX-SERVICEMEN'S ADVISORY COMMITTEE

Appearances: Mr. J.L. Varley, M.M.  
Mr. Andrew M. Gillespie,  
M.M.

MR. VARLEY: Before I start, I must say that in no way do we wish any inference to be taken from our brief with regard to the present treatment given to the veteran in Canada. We feel that the treatment given to veterans in Canada is the finest in the world, but there are some areas which could be altered.

THE CHAIRMAN: Would you introduce the gentleman with you?

MR. VARLEY: I would like to introduce Mr. Andrew M. Gillespie, M.M., who, I thought, you had already met, the Chairman of the Toronto and District Ex-servicemen's Advisory Committee.

The first paragraph of our brief, in view of the putting of our appearance forward, we were



THE CHAIRMAN: Now, ladies and gentlemen, if we may come to order we will discuss the case of the Ontario and Quebec.

THE CHAIRMAN: The first question is the Ontario and Quebec. The Government's Advisory Committee, I believe, will present the submission, and I will be pleased to

--- EXHIBIT NO. 32: Submission of the Ontario and Quebec

SUBMISSION OF THE ONTARIO AND QUEBEC  
EX-REVENUE'S COMMITTEE

Mr. Chairman, ladies and gentlemen,

Mr. Chairman: Before I start, I want

say that in no way do we wish any reference to be taken from our brief with regard to the present treatment given to the veteran in Canada. We feel that the treatment given to veterans in Canada is the best in the world, but there are some areas which could be improved.

THE CHAIRMAN: Would you introduce

the matter as well as you?

Mr. Chairman: I would like to introduce

Mr. Andrew W. Gifford, M.P., who, I thought, you had already met, the Chairman of the Ontario and Quebec Ex-Servicemen's Advisory Committee.

The first paragraph of our brief, in view of the nature of our submission, we want



Varley

11341

not able to have our entire group with us, but I will read the brief.

We are appearing before you today in the interest of Living Canadians who might easily have been among the victims of the wars that this country has taken part in. Were this November we could cite cases of valour performed, and the number of years service which is represented by these few veterans present, this adding weight to our request for consideration.

We don't wish to do this. We feel that our case needs no added impetus. We believe that our request stands by itself.

The case is simple, due to the load in Departmental hospitals and the lack of nursing staff, it has been necessary for the authorities to close down certain wings of some Departmental hospitals. The hospital that we are primarily interested in, of course, is the Sunnybrook Veterans' Hospital. On the gate going into the grounds of the hospital it states that they will respect the dead by caring for the living. I will defy any ordinary veteran to go to Sunnybrook and be admitted, even though there are over a hundred empty beds in the hospital.

We point out that there is a need for these closed wards to be opened. We point out also that the only way in which this can be done is by having available more trained nurses. Male orderlies are easily trained. Doctors can be hired as Sunnybrook is a training hospital and can use Interns as floor





not able to have an article published with me, but I

he and I were on different sides in

the interest of his own country and his own people  
have been among the victims of the war; that this  
country has taken part in a war of a hundred years  
could give cause of various problems, and the number  
of years service which is required by a few  
veterans present, this adding weight to our request  
for consideration.

He can't think to do this, he feels

that our case needs no other interest. He follows and  
can request again by itself.

The case is simple, the in the form

in governmental hospitals and the lack of staff  
staff, it has been necessary for the authorities to  
close down certain wings of some governmental hospitals.  
The hospital that we are currently interested in, it  
course, is the "Lambeth Veterans' Hospital". In the  
gate going into the grounds of the hospital it states  
that they will not accept the war for the living.  
I will only say ordinary veterans go to the hospital  
and he himself, even though there are some hundred  
cases in the hospital.

He points out that there is a need for

to be closed down to be opened, but I am not sure

that the only way in which it can be done is by

having a suitable new building erected. The original

and existing building, however, can be used for a number

of a building, but it will not be the same as the



Vorley

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doctors. But, and this is a big BUT, due to the present system of training there just are not enough nurses available nor will there be enough unless some steps are taken. More so when we read of the American hospitals inviting Canadian nurses to enjoy their hospitality for more money and better working conditions than those enjoyed at home.

We feel this can be overcome if a realistic look will be taken at the qualifications presently required to allow a young girl to take training as a nurse. It is our opinion that these qualifications are set too high entirely. It would be more in keeping with the principle behind this noble profession if some test were made to be certain that the trainee has the particular personality needed for this work.

We would suggest at this time that some consideration be given to lowering the actual academic standard a little and making sure that you are getting dedicated young women who will not be running off to higher paid jobs as soon as the training period is over and that some test be devised, call it suitability or personality or just the old job analysis, as you will, but get girls who are going to be dependable, dedicated nurses, and I really do believe that there are a lot of these who are being refused the opportunity to train for this profession.

COMMENT

While the treatment regulations of the Department of Veterans' Affairs have provision for



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doctors. But, and this is a big if, due to the present system of training there, and the not enough nurses available now will there be enough unless some steps are taken. More and more of the American hospitals having foreign nurses to enjoy their hospitality for some money and better working conditions than those enjoyed at home.

As far as this can be overcome if a realistic look will be taken at the qualifications presently required to allow a young girl to take training as a nurse. It is our opinion that these qualifications are set too high entirely. It would be more in keeping with the spirit of nursing to have a profession in some test case made to be certain that the trainee has the personality needed for this work.

We would suggest at this time that some consideration be given to lowering the actual academic standard a little and making sure that you are getting dedicated young women who will not be running off to higher paid jobs as soon as the training period is over and that some test be devised, call it suitability or personality or just one or two standards, as you wish, but get girls who are going to be dependable, dedicated nurses, and then to believe that there are a lot of these who are being refused the opportunity to train for this profession.

While the treatment of the Department of Veterans Affairs is being considered for





Varley

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the hospitalization of almost any class of Ex-serviceman, at the present time due to the shortage of nursing staff many veterans are not being admitted except after considerable delay.

There also is the fact that if a veteran is in a Departmental hospital for any illness the record of that illness is kept on his Departmental file. Such is not the case if he has to go to other than Departmental hospitals.

We feel that if the above noted recommendations are augmented more veterans will be able to enter veterans' hospitals. This will relieve the bed space situation in non-veteran hospitals and the entire country will benefit.

In closing we wish to thank you for listening to us. We hope that our words will not be forgotten too soon and that some consideration can be given to our recommendation with regard to the lowering of the standards to qualify for training as a nurse.

THE CHAIRMAN: Thank you, Mr. Varley, and thank you also for accepting our invitation to come this morning.

MR. VARLEY: Well, thank you, sir, for putting it forward. It gets a load off our mind at a busy time of the year.

THE CHAIRMAN: Well, it works out this way, and we are obliged to you for having accepted the invitation to come this morning.

Your basic proposition here is that because there is a shortage of nurses certain wards are



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the hospitalization of almost any class of Tx-servicemen at the present time due to the shortage of hospital staff. Many veterans are of the restricted category and considerable help.

There is no real lack of a veteran in a Departmental hospital for any illness the record of that illness is kept on the Departmental file. Such is not the case in the case of the other than Departmental hospitals.

We feel that if the Government could accommodate the augmented non-veteran who is able to enter Veterans' hospitals. This will relieve the bed space situation in non-veteran hospitals and the entire country will benefit.

In closing we wish to thank you for listening to us. We hope that our words will not be forgotten too soon and that some consideration can be given to our recommendation with regard to the lowering of the standards to qualify for housing as a result.

and thank you also for accepting our invitation to come this morning.

MR. WALKER: Well, thank you, sir,

for putting it forward. It goes to the top of the list at a very early time of the year.

MR. WALKER: Well, it would not this way, and we are obliged to the Government for the invitation to come this morning.

Thank you for your invitation to come this morning. I would like to see a shortage of houses here in this area.



Varley

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closed that you say should be opened?

MR. VARLEY: In their entirety, yes.

THE CHAIRMAN: And if those wards were opened they would be more accessible to veterans needing hospitalization; and secondly, it would relieve the general hospital situation but you come to your basic proposition that there is a shortage of nurses because the entrance qualification is being set too high.

As I understand it -- it is what?

MR. VARLEY: Grade 13.

THE CHAIRMAN: Grade 13 in Ontario and Grade 12 is the corresponding grade in other provinces. How do you arrive at this? Is this just a general idea? Have you got anything from which you make this suggestion that if we took, say, Grade 11, or Grade 10, that we would get many more nurses?

MR. VARLEY: Well, we are of the opinion that there may be, we know there are throughout the country, young girls who, because of this situation, are being let out, or left out, of the opportunity of taking nurse's training, unless they further their education which, after they have furthered it, usually takes them over the age limit to take this training.

THE CHAIRMAN: Well now, by age limit do you mean the age at which they might normally go in?

MR. VARLEY: Yes.

THE CHAIRMAN: There has been no suggestion of an age limit?

MR. VARLEY: Yes, except that they





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Why?

closed that you say should be denied?

MR. VAILLANT: In their entirety, yes.

THE CHAIRMAN: And if those things

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the general hospital situation but you come to your

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or Grade 10, that we would get many more nurses?

MR. VAILLANT: Well, we are of the

opinion that there may be, we know there are throughout

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MR. VAILLANT: Yes, except that they



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Varley

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would be a lot older when they graduate than the  
accepted, or the usual age for nurses.

THE CHAIRMAN: I understand the  
regulations are 17-and-a-half to 35.

MR. VARLEY: But they would be consi-  
derably older than the usual trainee is by the time  
they got this extra education.

THE CHAIRMAN: Grade 13?

MR. VARLEY: Yes.



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accepted, on the usual age for nurses.

THE CHAIRMAN: I understand the

regulations are 17-5-a-half to 22.

MR. VANDER: But they would be conse-

derably older than the usual trainee is by the time

they get this extra education.

THE CHAIRMAN: Grade 13?

MR. VANDER: Yes.





Varley

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pw THE CHAIRMAN: It has been told to us,  
and I think we know just from what goes on, that the  
real - you say, in the second paragraph on page 2,  
the loss - they no sooner get a graduate than they are  
lost to the profession.

MR. VARLEY: Not so much to the  
profession as to the hospitals generally. They go off  
on a higher paid position, perhaps specializing or  
something of that nature.

THE CHAIRMAN: We have been told that  
the greatest loss comes from the fact that they get  
married.

MR. VARLEY: I don't think that bars  
them from working. We have them in Sunnybrook.

THE CHAIRMAN: A great part of the  
force is married, perhaps those who are continuing to  
work or those whose family have attained a certain age  
and they are in a position to go back to work.

MR. VARLEY: Yes.

COMMISSIONER GIRARD: May I give one  
reason why I think it would be very difficult to lower  
the standards of young girls going into nursing today.  
In fact, we haven't highered the standards for a  
number of years, but nursing has changed considerably  
in the last 10 or 15 years. Nurses are now called upon  
to perform functions and tasks that some years ago  
were primarily the privilege of the medical profession,  
and as the medical sciences go along the physicians  
cannot do all these things they were doing years ago.  
Nurses have to be better prepared in order to cope with



THE CHAIRMAN: I have just told you  
and I think we know just what we mean by that. It  
isn't - you see, in the same way as we have  
the idea - then no sooner do we get into the  
fact of the proposition.

THE CHAIRMAN: I have just told you  
proposition as to the fact that they go on  
on a higher paid position, perhaps a higher  
something of that nature.  
THE CHAIRMAN: I have just told you  
the greatest loss comes from the fact that they are  
married.

MR. WALKER: I don't think that was  
then lost working. We have seen in Germany  
THE CHAIRMAN: A great part of the  
force is married, perhaps those who are not going to  
work on those whose family have obtained a certain  
and they are in a position to be able to work.

MR. WALKER: Yes.  
THE CHAIRMAN: I don't think that was  
reason why I think it would be very difficult to have  
the same sort of young girls who are not married today.  
In fact, we haven't a chance of a married woman  
married a woman, but married and changed completely  
in the last 10 or 15 years. I think we have lost a lot  
to perform functions and tasks that some years ago  
were given to the girl, but the medical profession,  
and as the medical profession is doing the same thing  
cannot do all these things that were done 10 or 15 years ago.  
I think we have to be better prepared in order to do the



Varley

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this. They have to know chemistry, to know physics, to know how to take care of oxygen tents and every kind of apparatus that comes into the hospital, and the nurse has to know how to cope with them. This is one of the reasons why she has to be better educated, and if she were not I think the care of the sick would not be very safe, because there are some pieces of equipment that, if you turn the flow of air one way you will get more oxygen, if you turn the flow the other way you get suction. This could mean life or death.

This is one example to show that the nurse has to be better educated.

We take the students at 17-and-a-half, and I know we could not take them at any earlier age because they are very immature even at that age. It is still very difficult to take a young girl at that age and to put her in the serious positions that we put a young nursing student in, with the life of the patient in their hands.

MR. GILLESPIE: What about the training, education?

COMMISSIONER GIRARD: We have to take care of the academic side as well as the other side.

MR. VARLEY: If the girl has the suitability and personality for this type of work, a little lower basic education would be taken care of. Particularly when we see a girl who takes training in laboratory or whatever, she has the basic education, and added education could be given during her training period.







Varley

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COMMISSIONER GIRARD: When a girl takes stenography she has nobody's life in her hands. The only thing she can waste is paper and time.

THE CHAIRMAN: And her employer's nerves.

COMMISSIONER GIRARD: A young nurse has to have judgment, she has to have a certain education in the sciences, and it is not only a nice personality, although we do want that, but it is not sufficient to have a nice personality.

MR. VARLEY: I didn't mean ugly, I meant adaptability.

COMMISSIONER GIRARD: We do want that, but that is not enough, just to come and smile.

MR. VARLEY: We don't want to have a bunch of what was formerly considered movie-picture types on the job. It does take certain types to do the job properly, and if they were screened in that way it is still our opinion that the need for higher education would not be required; the girls would be chosen. When a girl goes into high school now it is pretty well predestined what she is to be, and if her family can afford to carry her through the school she makes application for training.

Now, I don't know how many are refused. I would venture to say there are quite a number who enter who are not adapted to this work, whereas there are others who could undertake this training but are unable to enter into it who could make perfectly good nurses.

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Varley

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COMMISSIONER VAN WART: You are advocating the introduction of the Sunnybrook type as an assistant?

MR. VARLEY: No. They also have nursing assistants in Sunnybrook. It can also relieve the general pressure on all hospitals, where a lower standard is given in the education and better training is given in the professions and allow more girls to enter.

COMMISSIONER STRACHAN: What relationship does your Committee bear to the Royal Canadian Legion?

MR. VARLEY: None, other than the fact that we have representation at the meeting which sits monthly. It is composed of some 24 organizations in the Toronto area. We meet once monthly from September to June to discuss problems relative to the veterans, whether it be his specific veteran problem or whatever, for the good and welfare of the veteran and his family.

COMMISSIONER STRACHAN: Is it complementary to the efforts of the Committee?

MR. VARLEY: If our meeting had been at the time we were to have come we would have had the second Vice-President of the provincial command with us, and also someone from the War Amputations. We represent all of them this morning.

COMMISSIONER STRACHAN: Then you have some relationship?

MR. VARLEY: Yes, we work in very close conjunction with them.





Varley

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THE CHAIRMAN: Mr. Varley, on this page 2, where you refer to the fact that if a veteran is in a departmental hospital for any illness a record of that illness is kept in his departmental file, which is not the case if he goes to a hospital other than a departmental hospital.

MR. VARLEY: To qualify that, every veteran has a departmental file. When he enters hospital three copies of his hospital record are made; one is set to Ottawa, one is kept on the hospital file, one is kept on his departmental record. If he goes to a general hospital they have no record of that unless they ask to obtain it.

THE CHAIRMAN: You want the procedure which obtains in the departmental hospital to apply also in the general hospital?

MR. VARLEY: Yes, because it is our contention that, taking a longer view on this, if a man, after many years, comes up, perhaps, for a pensionable disability, if he has been to a general hospital for his illness there is no record and consequently there is no basis to deal with his future.

The veteran on the street is not cognizant of this, whereas we, in the veteran movement, are.

THE CHAIRMAN: You say that some arrangement might be made with a person on admission that would establish that he was a veteran and the machinery would automatically take over?

MR. VARLEY: Yes, the machinery to see





THE CHAIRMAN: Mr. Varley, on this

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THE CHAIRMAN: You say that some

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that would establish that he was a veteran and the

arrangement would automatically take effect?

MR. VARLEY: Yes, the machinery to be



Varley

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that a copy of that goes to the department.

MR. GILLESPIE: There is also the consideration of training nurses in departmental hospitals, a very important thing.

THE CHAIRMAN: Are there training schools in the department?

MR. GILLESPIE: No, not at all.

THE CHAIRMAN: You think that would be a practical thing and beneficial in the way of recruitment?

MR. GILLESPIE: Very good, yes.

THE CHAIRMAN: As I understand it, the type of training in the veterans' hospital or departmental hospital is not as broad and as general as in the general hospital?

MR. VARLEY: It has become increasingly broader when we consider there are 29 types of things he can be admitted for.

THE CHAIRMAN: Well, it is a recommendation which we have noted, and we have studies being made for the Commission in connection with nursing, nursing education, nursing recruitment, and your recommendation will go to the departments making those studies.

MR. VARLEY: Thank you very much, sir.

THE CHAIRMAN: Thank you very much, Mr. Varley and your associate.

MR. VARLEY: Mr. Gillespie and I, on behalf of the Advisory Committee, wish to thank you very much for having heard us. We regret we were not



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Varley

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MR. GILLESPIE: There is also the

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made for the Commission in connection with nursing,

training education, nursing recruitment, and your

recommendation will go to the department's working, those

educational.

MR. VARLEY: Thank you very much, sir.

THE CHAIRMAN: Thank you very much.

Mr. Varley and your associates.

MR. VARLEY: Mr. Gillespie is here, or

on behalf of the Advisory Committee, wish to thank you

very much for having heard us. We regret we were not





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Varley

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3 able to have more people out to show our strength,  
4 but I can assure you we have this matter at heart.  
5 While we believe, in Canada, we have the finest legis-  
6 lation for ex-servicemen, unless we are constantly  
7 aware of the need to keep on top of this thing it  
8 could easily slip down a little bit.

9 Thank you very much for having seen  
10 us.

11 THE CHAIRMAN: Thank you, Mr. Varley,  
12 Mr. Gillespie.

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able to have more people out to show our strength,  
but I can assure you we have this matter at heart.  
While we believe, in Canada, we have the finest legis-  
lation for environmental protection, unless we are constantly  
aware of the need to keep on top of this thing it  
could easily slip down a little bit.  
Thank you very much for having been

THE CHAIRMAN: Thank you, Mr. Varley,

Mr. Varley.

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THE SECRETARY: Mr. Chairman, the next submission is the Canadian Conference of Pharmaceutical Faculties. Dr. Huston will present this submission and introduce his colleagues to the Commission. It will be known as Exhibit 321.

--- EXHIBIT NO. 321: Submission of the Canadian Conference of Pharmaceutical Faculties.

SUBMISSION OF THE CANADIAN CONFERENCE OF  
PHARMACEUTICAL FACULTIES

Appearances: Dean M.J. Huston  
Dean A.W. Matthews  
Dean F.N. Hughes

DEAN HUSTON: Mr. Chairman, members of the Commission, I am Dr. M.J. Huston, Dean of the Faculty of Pharmacy, University of Alberta, and I represent the Canadian Conference of Pharmaceutical Faculties. Dr. A.W. Matthews, Dean of the Faculty of Pharmacy, University of British Columbia, is on my right and on my left, Dr. F.N. Hughes, Dean of the Faculty of Pharmacy, University of Toronto.

I would like, first of all, to introduce two exhibits. We have here a set of the calendars of several faculties of pharmacy in Canada; that will be the first exhibit, and I have here some programs of the Canadian Conference on Pharmaceutical Research which have been held over the last few years. We thought it might be of some interest.

THE SECRETARY: Mr. Chairman, the first one will be Exhibit 321A and the latter 321B.



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--- EXHIBIT NO. 321: Submission of the Canadian Conference of Pharmaceutical Faculties.

SUBMISSION OF THE CANADIAN CONFERENCE OF PHARMACEUTICAL FACULTIES

Apparances: Dean L.J. Huston  
Dean A.W. Matthews  
Dean F.N. Hughes

DEAN HUSTON: Mr. Chairman, members

of the Commission, I am Mr. L.J. Huston, Dean of the Faculty of Pharmacy, University of Alberta, and I represent the Canadian Conference of Pharmaceutical Faculties. Dr. A.W. Matthews, Dean of the Faculty of Pharmacy, University of British Columbia, is on my right and on my left, Dr. F.N. Hughes, Dean of the Faculty of Pharmacy, University of Toronto.

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THE SECRETARY: Mr. Chairman, the first one will be Exhibit 321 and the latter 322.



Huston

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--- EXHIBIT NO. 321A: Calendars of several faculties  
of pharmacy in Canada.

--- EXHIBIT NO. 321B: Programs of the Canadian  
Conference on Pharmaceutical  
Research.

DEAN HUSTON: The first thing I would  
like to point out is a typographical calamity which  
came about. On the second page, where it says:

"Presented by - Chairman, Committee  
on Health Services, Canadian  
Foundation for the Advancement of  
Pharmacy",

it should read:

"The Canadian Conference of Pharma-  
ceutical Faculties."

I am Chairman of the Committee of the  
Foundation, but not this one. It is on the second page  
right after the frontispiece, sir. It is on an un-numbered  
page, which is the second page you come to if you start  
at the front.

I wish to read the summary and recommen-  
dations if that is proper, sir.

--- THE 817 NO. 311A: A series of several facilities  
of pharmacy in Canada.

--- THE 817 NO. 311B: A series of the Canadian  
pharmaceutical industry.

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SUMMARY AND RECOMMENDATIONS

Part I.

Identity of the Canadian Conference of  
Pharmaceutical Faculties.

1. The Canadian Conference of Pharmaceutical Faculties is a voluntary organization comprising of all of the pharmacy colleges in Canada.

Part 2.

Objectives of the Canadian Conference  
of Pharmaceutical Faculties.

1. To promote pharmaceutical education and research.

2. To provide an opportunity for the exchange of ideas and the discussion of curricula and teaching methods with a view to their continual improvement.

3. To make recommendations to the Council of the Canadian Pharmaceutical Association regarding educational policies and the advancement of the science and practice of pharmacy.

4. To encourage high and uniform educational standards in pharmacy throughout Canada.

Part 3.

Scope of Modern Pharmacy.

3. The remarkable development in the efficiency of therapeutic agents has had a revolutionary effect upon the practice of medicine and the role of pharmacy therein. The responsibilities of the pharmacist, as a drug specialist, have increased markedly although



THE CANADIAN PHARMACEUTICAL

Part I.

History of the Canadian Conference of

1. The Canadian Conference of Pharmaceutical Technicians is a voluntary organization comprising of all of the pharmacy colleges in Canada.

Part II.

Objectives of the Canadian Conference

of Pharmaceutical Technicians.

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2. To provide an opportunity for the exchange of ideas and the discussion of technical and teaching methods with a view to their continual improvement.

3. To make recommendations to the Council of the Canadian Pharmaceutical Association regarding educational policies and the advancement of the science and practice of pharmacy.

4. To encourage high and uniform educational standards in pharmacy throughout Canada.

Scope of Modern Pharmacy.

5. The remarkable development in the efficiency of therapeutic agents has had a revolutionary effect upon the practice of medicine and the role of pharmacy therein. The responsibilities of the pharmacist as a specialist, have increased markedly since



changed in form. The increased responsibility has necessitated a modification and extension of educational training.

4. The function of the modern practising pharmacist is described.

Part 4.

Education.

1. Historical Background.

5. Formal education for pharmacy has changed from an apprenticeship system to an academic discipline within a university. The eight colleges of pharmacy in Canada are integral divisions within universities and the basic degree awarded is the baccalaureate degree in pharmacy.

2. Curriculum Development.

6. Under the stimulus of the Conference the curriculum of studies has been soundly adjusted to meet the increasing and changing responsibilities of the modern pharmacist.

7. The basic considerations, specific objectives and organization of courses of the modern pharmacy curriculum are described. The combination of courses in:- Physical and Biological Sciences, Professional Subjects, Pharmacy Administration and General Education provides a well-rounded educational experience for the pharmacy graduate.

3. Specialization.

8. The increased complexity of pharmacy has led to a degree of specialization and adaption of the curriculum to make this possible.

(a) Hospital Pharmacy.





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(a) Hospital Pharmacy.



9. The hospital pharmacist plays a vital role in the operation of a modern hospital. Specialized training for hospital pharmacists is available in the several colleges.

10. The number of hospitals is increasing markedly throughout the country and this will undoubtedly continue in the future. It is the firm opinion of the Conference that adequate pharmaceutical services should be provided for every hospital, either through one or more full-time pharmacists, in the case of the larger hospital, or in the case of small institutions, by part-time pharmacists or local retail pharmacists. In view of the potency and danger of many modern drugs and the protection, efficiency and economy which a pharmacist can provide, the Conference recommends that the Commission affirm in its findings that drug service in all hospitals should be under the control of a registered pharmacist.

(b) Retail Pharmacy.

11. The practice of retail pharmacy is as much a specialty as any other branch of pharmacy. The retail pharmacist, in addition to conducting a highly specialized profession, must operate a complex and competitive business. The curriculum takes this into account and provides courses designed to prepare the practitioner in sound business methods.

(c) Manufacturing and (d) Analysis and Control.

12. The curriculum allows for areas of specialization as preparation for opportunities in the drug manufacturing industry and in government laboratories.

(e) Inspection Service.



9. The hospital pharmacist plays a vital role in the operation of a modern hospital. Specialized training for hospital pharmacists is available in the several colleges.

10. The number of hospitals is increasing markedly throughout the country and this will undoubtedly continue in the future. It is the firm opinion of the conference that adequate pharmaceutical services should be provided for every hospital, either through one or more full-time pharmacists, in the case of the larger hospital, or in the case of small institutions, by part-time pharmacists or local retail pharmacists. In view of the potency and danger of many modern drugs and the protection, efficiency and economy which a pharmacist

should be under the control of a registered pharmacist.

(a) Retail Pharmacy.

11. The practice of retail pharmacy is as much a specialty as any other branch of pharmacy. The retail pharmacist, in addition to conducting a highly specialized profession, must operate a complex and competitive business. The curriculum takes this into account and provides courses designed to prepare the practitioner in sound business methods.

(b) Manufacturing and (c) Analysis and Control.

12. The curriculum allows for areas of specialization in preparation for opportunities in the pharmaceutical industry and in government laboratories.

(d) Research Service.





13. The Conference feels that the present grouping by Federal administration of food and drugs together is unwieldy, inefficient and unsatisfactory. The Conference therefore supports the recommendation of the Canadian Pharmaceutical Association that the Food and Drug Directorate be divided into two parts, one dealing with Drugs and one with Food; that all drug inspectors of retail and manufacturing establishments be pharmacists; that pharmacists be involved in the administration of such procedures; that pharmacists be employed in the control laboratories; and that individuals with a baccalaureate degree in pharmacy be eligible for position as analytical chemists.

14. The Conference further recommends that all narcotic and schedule G drug inspectors be pharmacists.

(f) Emergency Health Services.

15. In disaster planning large quantities of drugs are being stock-piled. Since the country has a large investment in such supplies these should have adequate supervision and control. The Conference therefore recommends that in all Emergency Health Services planning stocks of drugs be under the control of registered pharmacists.

(g) Administration.

16. The curriculum allows for some degree of specialization for people wishing to prepare themselves for executive responsibilities.

(h) Manufacturers' Representatives.

17. Since it is felt that the manufacturers' representatives serve a very useful function when well qualified, the Conference recommends that pharmaceutical

The Conference feels that the present  
provision by Federal administration of food and  
supplies is unworkable, inefficient and unsatisfactory.  
The Conference therefore supports the recommendation of  
the American Pharmaceutical Association that the  
Federal Government be divided into two parts, one  
dealing with drugs and one with food; that all  
activities of retail and manufacturing establishments be  
regulated; that pharmacists be involved in the  
administration of such procedures; that pharmacists be

included in analytical chemistry.

14. The Conference further recommends that  
all scientific and technical data, information be  
(1) Emergency Health Services.  
15. In disaster planning large quantities  
of drugs are being stockpiled. Since the country has  
a large inventory in such supplies there should be  
adequate supervision and control. The Conference therefore  
recommends that in all Emergency Health Services planning  
stockpiles should be under the control of retail

(16) Administration.

17. In addition we advise for some  
of specialization for people wishing to prepare themselves  
for disaster responsibilities.  
(18) Pharmaceutical Representation.  
19. It is felt that the  
representatives have a very limited knowledge of  
pharmaceuticals, the Conference recommends that



1  
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4 firms be urged to use only pharmacists or other scientifically  
5 well qualified personnel as medical service  
6 representatives.

7 (i) Research.

8 18. The undergraduate course in pharmacy  
9 gives an excellent foundation for those wishing to  
10 proceed to graduate study and a career in research.

11 4. Facilities.

12 19. The Canadian pharmacy colleges have  
13 present or planned space and facilities which are, for  
14 the most part, adequate for the immediate future. In  
15 the years ahead, with the exploding university popu-  
16 lations, additional space and equipment will be needed  
17 and adequate funds will have to be forthcoming.

18 20. The Conference recommends that  
19 substantial federal and provincial funds be allocated  
20 to the universities for building and equipment.

21 5. Scholarships and Other Financial  
22 Assistance.

23 21. The Conference feels that no person  
24 with the ability to undertake university work should be  
25 prevented from so doing for financial reasons. The  
26 Conference therefore recommends that there be a  
27 substantial increase in public funds allocated to the  
28 support of university students.

29 6. Academic Personnel.

30 22. The Conference draws attention to the  
present and future shortage of candidates qualified for  
academic posts at universities.

7. Continuing Education for Practising  
Pharmacists.





It is hoped to use only pharmacists or other scientific  
personnel in medical service

(1) Research.

The undergraduate course in pharmacy  
 gives an excellent foundation for those wishing to  
 proceed to graduate study and a career in research.

The Canadian pharmacy colleges have  
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 the most part, adequate for the immediate future. In  
 the long run, with the exploding university popula-  
 tions, additional space and equipment will be needed  
 and adequate funds will have to be forthcoming.

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substantial federal and provincial funds be allocated  
to the universities for building and equipment.

5. Scholarships and Other Financial

The Conference feels that no person  
 with the ability to undertake university work should be  
 prevented from so doing for financial reasons. The  
 Conference therefore recommends that there be a  
substantial increase in available funds allocated to the  
study of those with aptitudes.

6. Academic Council.

The Conference draws attention to the  
 present and future shortage of candidates qualified for  
 university positions.

7. Continued Attention for Research



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23. In view of the necessity of keeping up-to-date in the rapidly developing field of drug therapy and the difficulty of doing so, the Conference recommends that refresher courses be extended and formally organized on a regular basis under a Department of Continuing Education within a faculty or under other auspices and that the provincial pharmaceutical licensing bodies give consideration to making such courses compulsory for their licentiates.

8. Pharmacy Examining Board of Canada.

24. In order to establish a high level of pharmaceutical education throughout Canada and to facilitate movement of pharmacists the Conference recommends that the Royal Commission on Health Services endorse the establishment of a Pharmacy Examining Board of Canada.

9. Practical Training.

25. The period of practical training is presently undergoing study and experimentation and can be considered to be in a transitional state.

10. Canadian Foundation for the Advancement of Pharmacy.

26. The Foundation is a philanthropic organization which has contributed over a quarter of a million dollars in support of pharmaceutical education and research since its establishment in 1945.

11. Education for the Future.

27. The colleges recognize that the educational programme in pharmacy must prepare graduates not only for current practice but also for the future.



23. In view of the necessity of keeping

up-to-date in the rapidly developing field of drug therapy and the difficulty of doing so, the Conference

recommends that reference courses be extended and formally organized on a regular basis under a Department

of Continuing Education with

associates and that the provincial pharmaceutical licensing bodies give consideration to making such

courses compulsory for their licensees.

2. Pharmacy Examining Board of Canada.

24. In order to establish a high level of

pharmaceutical education throughout Canada and to

facilitate movement of pharmacists the Conference

has decided that the Royal Commission on Health Services

endorse the establishment of a Pharmacy Examining Board

of Canada.

3. Practical Training.

25. The period of practical training for

presently undergoing study and experimentation and are

be considered to be in a transitional state.

26. Canadian Foundation for the

Advancement of Pharmacy.

27. The Foundation is a philanthropic

organization which has contributed over a number of

million dollars in support of pharmaceutical education

and research since its establishment in 1945.

28. Association for the Future.

29. The old age pensioners that the

educational programs in pharmacy must prepare graduates

not only for current practice but also for the future.





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4 28. The practice of pharmacy is undergoing  
5 an evolution due to the stimulus of advancing medical  
6 knowledge and the pressure of commercial factors. The  
7 Conference would urge that pharmacists in the future  
8 confine themselves to the handling of health needs insofar  
9 as is economically feasible and, in the interest of  
10 public safety, that health needs be provided only in  
11 pharmacies. In order to improve pharmaceutical practice  
12 and to make efficient use of manpower, The Conference  
13 recommends that the Royal Commission on Health Services  
14 approve the concept of accreditation of pharmacies, to  
15 be based upon a specified standard of practice. The  
16 Conference further recommends that in the establishment  
17 of any health care programme pharmaceutical service  
18 be provided only in pharmacies accredited by the provincial  
19 licensing bodies. The conference is of the opinion that  
20 drugs and all pharmaceutical services should be supplied  
21 directly to the public only by pharmacists through legally  
22 authorized and regulated retail pharmacies of the  
23 provinces.

21 12. Enrolment.

22 29. The number of pharmacists graduated in  
23 Canada over the past 10 years is presented.

24 30. The pharmaceutical manpower survey  
25 recommended by the Canadian Pharmaceutical Association  
26 will give the colleges valuable information to guide  
27 them in planning for the future.

28 13. Statement by the University of  
29 Montreal and Laval University.

30 31. The Faculty of Pharmacy of the University

The practice of pharmacy is undergoing

an evolution due to the stimulus of advancing knowledge and the pressure of commercial factors. The

Commission would urge that pharmacists in the future

concentrate themselves to the handling of health needs instead

of being theoretically feasible and, in the interest of

public safety, that health needs be served only in

the following manner:

1. The Commission on Health Services

recommends that the Royal Commission on Health Services

approve the concept of accreditation of pharmacies, to

be based upon a specified standard of practice, and

2. The Commission on Health Services

recommends that in the establishment

of any health care organization pharmaceutical services

be provided only in pharmacies accredited by the provincial

licensing bodies. The Commission is of the opinion that

drugs and all pharmaceutical services should be supplied

directly to the public only by pharmacists through legally

authorized and regulated retail pharmacies or the

Commission on Health Services

17. Enclosure.

The number of pharmacists practising in

Canada over the past 10 years is presented.

18. The pharmaceutical manpower survey

conducted by the Canadian Pharmaceutical Association

will give the colleges valuable information to guide

them in planning for the future.

19. Statement by the University of

Alberta and Saskatchewan.

The Faculty of Pharmacy of the University



1  
2  
3 of Montreal and the School of Pharmacy of Laval  
4 University endorse this brief but do not feel competent  
5 to agree with the recommendations 7, 8 and 11 because  
6 these colleges of pharmacy consider that the points  
7 stressed in these recommendations refer directly to the  
8 practice of pharmacy, over which the provincial  
9 licensing bodies have the control and full responsibility.  
10 Part 5.

#### 11 Research and Graduate Studies.

12 32. Paragraphs 1, 2 and 3. The nature and value of  
13 university research in general and of pharmaceutical  
14 research in particular are discussed.

15 33. Since it is felt that it would be  
16 advantageous to the country if Canada were less an  
17 exploited market and more a self-contained entity, the  
18 Conference recommends that pharmaceutical firms  
19 operating in Canada be urged to spend more of the funds  
20 derived from Canadian sales on research in this country,  
21 and that a significant proportion of such funds be used  
22 to support basic research in the universities and in the  
23 pharmacy colleges in particular.

#### 24 4. Research Developments in Canadian 25 Colleges.

26 34. Information is presented which evi-  
27 dences the extent and high quality of research in the  
28 Canadian Pharmacy Colleges.

#### 29 5. Financial Requirements.

30 35. Since modern research is an expensive  
undertaking the Conference recommends increased aid from  
federal and provincial funds to enable to universities  
to provide buildings, equipment, supplies, salaries,  
additional staff and undergraduate and graduate





of Montreal and the School of Pharmacy of Laval  
University endorse this first but do not feel competent  
to make a final judgment. The second and third  
reports of pharmacy considered that the points  
stressed in these recommendations relate directly to the  
practice of pharmacy, over which the pharmacist  
licensing bodies have the control and full responsibility.

2. The nature and value of  
university research in general and of pharmaceutical  
research in particular are discussed.

3. Since it is felt that it would be  
advantageous to the country if Canada were less an  
exclusive market and more a self-sufficient entity, the

following recommendations are made:  
1. The government should encourage the development of  
pharmaceutical research in Canada by providing financial  
aid to the universities and to the private industry.  
2. The government should encourage the development of  
pharmaceutical research in Canada by providing financial  
aid to the universities and to the private industry.

4. The government should encourage the development of  
pharmaceutical research in Canada by providing financial  
aid to the universities and to the private industry.

5. The government should encourage the development of  
pharmaceutical research in Canada by providing financial  
aid to the universities and to the private industry.

6. The government should encourage the development of  
pharmaceutical research in Canada by providing financial  
aid to the universities and to the private industry.

7. The government should encourage the development of  
pharmaceutical research in Canada by providing financial  
aid to the universities and to the private industry.



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4 scholarships for both teaching and research. The  
5 Conference further recommends substantial and progressive  
6 increases in funds allocated to the National Research  
7 Council and to the Medical Research Council.

8 6. Present Status and Future  
9 Development.

10 36. In the future it is certain that one  
11 of the most dramatic changes in the educational picture  
12 of pharmacy will be the expansion of the graduate and  
13 research programmes. The colleges are planning for  
14 these developments.

15 THE CHAIRMAN: Thank you very much,  
16 Dr. Huston. I am going to make a suggestion to you  
17 and your associates: As you know, immediately after  
18 this brief we are going to have the submission of the  
19 Canadian Pharmaceutical Association. Now, there are  
20 many phases of the submissions which dovetail and  
21 overlap in some way and if it is agreeable to you  
22 gentlemen we would like to postpone the general dis-  
23 cussion until the other submission is given and then  
24 have sort of a co-ordinated discussion at that time.  
25 We know from past experience that the pharmaceutical  
26 people have been calling on you gentlemen at various times  
27 to enter into their discussions and I think it might  
28 make for a better, more complete picture and perhaps  
29 even a shorter one if we do the two of them at the one  
30 time if that is agreeable to you.

DEAN HUSTON: That will be satisfactory  
to us but I would point out that this conference brief  
is an independent and separate brief from any other group



and the end of the world.

development.

28.

In the future it is certain that one of the most important changes in the educational picture of pharmacy will be the expansion of the graduate and postgraduate. The colleges are planning for these developments.

THE CHAIRMAN: Thank you very much.

Mr. Chairman, I am going to make a suggestion to you and your associates: If you know, immediately after this I hope we are going to have the admission of the

new phases of the profession which develop and expand in some way and it is responsible to you. Therefore we want to postpone the general discussion until the other commission is given and then have sort of a coordinated discussion at that time. We know from past experience that the pharmaceutical people have been calling on you for a long time to expand their education and I think it right for a better, more complete picture and better even a chapter and a volume in the two of them at the end of that is responsible to

THE CHAIRMAN: I will be satisfied.

So is that all right that this committee have as independent and separate series from the other group





Huston

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2  
3 that have presented or will present but I see nothing  
4 wrong with your proposal.

5 THE CHAIRMAN: We accept that and are  
6 very conscious of it that this is a brief on behalf  
7 of the Colleges and there will be questions which will  
8 be directly specifically to you gentlemen this afternoon.

9 DEAN MATTHEWS: It places me in the  
10 position of having to wear two hats.

11 THE CHAIRMAN: I suppose in practice  
12 you would be doing that anyway. Mr. Turnbull, would this  
13 procedure be acceptable to you?

14 MR. TURNBULL: Yes, I believe this  
15 would be quite acceptable on the understanding that this  
16 is an independent brief, the brief that the Canadian  
17 Pharmaceutical Association is presenting is still an  
18 independent brief we would welcome joint discussion on  
19 these matters that can be dealt with jointly and still  
20 reserve the privilege of disagreeing with one another if  
21 such as necessary.

22 THE CHAIRMAN: Very well. We will rise  
23 now until two o'clock.

24 ---Lucheon Adjournment.  
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...a statement I will present but I see nothing

THE CHAIRMAN: We accept that and we

any conclusion of it that this is a point on which

of the College and there will be questions which will

be brought up specifically to you gentlemen this afternoon.

THE CHAIRMAN: It places me in the

position of having to wait two days.

THE CHAIRMAN: I suppose in practice

you would be doing that anyway, Mr. Turnbull, would this

problem be applicable to you?

MR. TURNBULL: Yes, I believe this

would be quite acceptable on the understanding that this

is an independent brief, the brief that the Canadian

International Association is presenting as still an

independent brief we would welcome joint discussion on

these matters that can be dealt with jointly and still

reserve the privilege of disagreeing with one another if

that is necessary.

now until two o'clock.



PB/ss

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---Upon Resuming at two o'clock

---Commissioner McCutcheon in the Chair.

THE ACTING CHAIRMAN: Ladies and gentlemen, the Chairman will be somewhat delayed in returning this afternoon. We will proceed now.

THE SECRETARY: The first brief, Mr. Chairman, is that of the Canadian Pharmaceutical Association, which will be known as Exhibit 322. The supplement thereto will be known as Exhibit 322A. Mr. Mr. Mitchell who is President of the Association will introduce the group.

S U B M I S S I O N O F  
THE CANADIAN PHARMACEUTICAL ASSOCIATION

---EXHIBIT NO. 322: Submission of the Canadian Pharmaceutical Association.

---EXHIBIT NO. 322A: Supplement.

APPEARANCES:

PROF. J.L. SUMMERS  
MR. J.C. TURNBULL  
DR. A.W. MATTHEWS  
MR. J.K. LAWTON  
MR. T.M. ROSS  
MR. D.F. McKEAGUE

MR. MITCHELL: Mr. Chairman and Members of the Commission, it is a pleasure to have this opportunity of appearing before you this afternoon and presenting our





---from meeting at two o'clock

---Commissioner for London in 1901

Mr. W. H. ... and

... the Chairman will be ... in

... this statement ...

Mr. ...

Chairman, is that of the ...

tion, which will be known as ...

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who is President of the Association will introduce the

Group.

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---EXHIBIT NO. 3A

---EXHIBIT NO. 3A

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... of the Commission, is a measure to ...

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Mitchell 11366

brief on behalf of the Canadian Pharmaceutical Association. I hope it is factual and I hope it is all encompassing and I also hope it is not too lengthy.

Mr. Chairman, we have our immediate Past President, Mr. Don McKeague, retail pharmacist from Calgary; our First Vice-President, Dr. Matthews, Dean of the Faculty of Teaching, University of British Columbia in Vancouver; our Second Vice-President, Mr. Keith Lawton, retail pharmacist from Halifax; the Chairman of our Health Matters Committee, Professor J. L. Summers of the University of Saskatchewan in Saskatoon and also with us is our Associate Secretary from our Toronto office, Mr. Tom Ross and our Secretary Manager, Mr. John C. Turnbull who will be presenting our submission.

THE ACTING CHAIRMAN: Thank you very much. Mr. Turnbull, I understand you are going to summarize the summary.

MR. TURNBULL: I shall attempt to, sir. I suppose I might open by saying the size of our brief is a bit of an indication of the weight with which we view this matter before the Commission. I have with me a summarization of our presentation for oral presentation today and I would ask, sir, that this summarization be taken as read, and with your permission I will merely highlight it in this oral presentation.

THE ACTING CHAIRMAN: Proceed any way that suits you best, Mr. Turnbull.

MR. TURNBULL: May I first enter as an Exhibit two items that are mentioned in the brief. The first is an extract from the September 1st issue,



of it in behalf of the American people, which is  
I hope it is factual and I hope it is all embracing  
and I also hope it is not too long.

Mr. Tolson, I have a few more  
points to make, but I will not make them from  
California, but I will make them from the  
the City of Washington, the City of the Nation.

Finally, I want to say that I am not an expert  
in the field of medicine, but I am an expert in the  
field of law, and I am an expert in the  
field of the Constitution, and I am an expert in  
the field of the Bill of Rights, and I am an expert  
in the field of the American people.

Mr. Tolson, I am not a lawyer, but I am a  
citizen, and I am a citizen of the United States,  
and I am a citizen of the State of California,  
and I am a citizen of the City of San Francisco,  
and I am a citizen of the County of San Francisco,  
and I am a citizen of the City and County of San Francisco.

Mr. Tolson, I am not a lawyer, but I am a  
citizen, and I am a citizen of the United States,  
and I am a citizen of the State of California,  
and I am a citizen of the City of San Francisco,  
and I am a citizen of the County of San Francisco,  
and I am a citizen of the City and County of San Francisco.





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1961, of the Canadian Pharmaceutical Journal being the compilation of the 19th annual survey of retail pharmacy operations.

THE SECRETARY: That will be Exhibit 322B, sir.

---EXHIBIT NO. 322B: September 1st issue of the Canadian Pharmaceutical Journal.

MR. TURNBULL: Secondly, I would submit the publication of our Association the Compendium of Pharmaceutical Specialties, Canada, 1960.

THE SECRETARY: Exhibit 322C.

---EXHIBIT NO. 322C: Compendium of Pharmaceutical Specialties, Canada, 1960.

MR. TURNBULL: Mr. Chairman and Members of the Commission -

It is the aim of this presentation by the Canadian Pharmaceutical Association to include constructive and factual information about the practice of Pharmacy and the distribution of drugs in Canada as such is known to the Association.

IDENTIFICATION:

The Canadian Pharmaceutical Association, Inc. is a voluntary federation of the provincial statutory Pharmacy organizations which are charged with the responsibility of the administration of provincial Pharmacy Acts. It is a non-profit professional association dedicated to its principal objective of advancing the science





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and practice of Pharmacy, while acting on behalf of its constituent associations and their members.

DRUG AND PHARMACEUTICAL LEGISLATION:

In Canada, the British North America Act clearly designates health matters as a provincial responsibility. Drugs, as such, are not specifically mentioned and thus, legislation pertaining to them involves matters of concern to both federal and provincial governments.

As Canada's population increases and its manufacturing industry expands, there is an increasing need for a well-defined departmentalization of food control and of drug control. The Association, therefore, recommends:

- (1) That in each of the Food and Drug Directorate divisions - namely, scientific services, inspection services, administrative services and five regional divisions - there be a more clear-cut differentiation between personnel involved and the duties of such personnel in respect to food control and to drug control;
- (2) That consideration be given to the establishment of either or both of (a) in addition to the present Deputy Minister (Medical) there be appointed a Deputy Minister (Pharmaceutical) and/or (b) the Director or an Associate Director of the Food and Drug Directorate possess a graduate degree in Pharmacy;
- (3) That (a) a therapeutics section be added to the present sections which are included in the





and practice of Pharmacy, while acting on behalf of the  
 constituent associations and their members.

In Canada, the Health Canada Agency  
 not clearly designated health matters as a provincial  
 responsibility. Drugs, as such, are not specifically  
 mentioned and thus, legislation pertaining to them  
 involves matters of concern to both federal and provincial  
 governments.

As Canada's population increases and  
 its manufacturing industry expands, there is an increasing  
 need for a well-defined governmental action or food  
 control and of drug control. The Association, therefore,

Recommendations:

- (1) That in each of the Food and Drug Divisions  
 divisions - namely, scientific services, in-  
 spection services, administrative services and  
 five regional divisions - there be a more  
 clear-cut division of labour between personnel  
 involved and the nature of each personnel's  
 respect to food control and to drug control.
- (2) That consideration be given to the estab-  
 lishment of either or both of (a) in addition to  
 the present Deputy Minister (General) there  
 be appointed a Deputy Minister (Scientific)  
 and/or (b) the Division of Scientific  
 Director of the Food and Drug Division  
 possess a scientific degree in pharmacy.
- (3) That (a) a Department of Food and Drug  
 be created at national level and be located in the



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central laboratories services division; and

(b) that pharmacists be appointed to the

technical staff of each regional laboratory;

(4) That, as in the Division of Narcotic Control,

(a) pharmacists be employed on the central

inspection staff whose responsibilities include

the inspection of drug manufacturing; and (b)

pharmacists be employed, at the regional

level, to conduct the inspection of pharmacy

establishments.

QUALITY CONTROL LEGISLATION:

Quantitative analysis of the finished product does not, by itself, necessarily establish all pertinent aspects of quality. Quality related to a drug preparation is something which must be built into it and cannot merely be tested into it. Governmental supervision should not be necessary and is probably impractical from a manpower viewpoint. It is, however, recommended that provision be made for it to be ordered where completely satisfactory methods are not in evidence in individual manufacturing operations. It is further recommended that manufacturers of drugs and drug preparations be licensed, and that such licensing be a prerequisite to manufacturing and a necessity for year-to-year continuation of manufacturing. Regulations providing for the stringent supervision of drug manufacturing facilities and control is an urgent need and the Association recommends the immediate implementation of the Regulations as set forth in a proposal by the Food and Drug Directorate in late December, 1960.



central laboratories as follows: (a) a

(b) that the laboratory is authorized to

conduct a study of each regional laboratory

(c) that, as in the division of laboratory work,

(d) the laboratory be equipped on the central

inspection staff those responsibilities include

the inspection of drug manufacturing; and (e)

the laboratory be equipped, at the regional

level, to conduct the inspection of pharmacy

establishments.

Quantitative analysis of the finished

product does not, by itself, necessarily establish all

relevant aspects of quality. Quality related to a drug

preparation is something which must be built into it and

cannot merely be tested into it. Governmental inspection

should not be necessary and is probably impractical from

a narrower viewpoint. It is, however, essential that

provision be made for it to be entered where completely

reliability of methods are not in evidence. It is

manufacturing operations. It is further recommended that

characteristics of drugs and drug preparations be included,

and that such monitoring be a prerequisite to manufacturing

and a necessity for quality control in manufacturing

testing. Regulations providing for the control of

quality of drug manufacturing facilities and control is an

urgent need and the Government is urged to take steps to

implementation of the regulations as set forth in

proposed by the Government and the industry in order to





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The Pharmacy practitioner must place a great deal of reliance upon his knowledge of the inherent integrity of the manufacturer in his evaluation of quality control. Thus, it is necessary for him to know the name of the actual manufacturer, in addition to the manufacturing distributor, and it is recommended that labels of drug preparations state both names where applicable.

Correction of Potential Hazards:

Secret formula drug preparations sold under the Proprietary or Patent Medicine Act are registered and their makers licensed. The Association continues to recommend that, in the best interest of the consumer, labels of all medicinal preparations should bear the common names of all active ingredients.

Further the Association expresses its concern over the advertising of medicinal products which does not give proper attention to the supplying of information which should be known to the consumer of potentially dangerous medications. It is recommended that more rigid screening of promotional claims concerning drugs and drug preparations be instituted.

The Association's professional interest in, and support of poison control procedures has caused it to recognize deficiencies in the methods by which decentralized locations across Canada are able to keep up-to-date files of the ever-increasing number of products on today's market. We recommend, therefore, that, in addition to hospital poison information centres, one central poison control office, established in the Department of National Health and Welfare in Ottawa, be operated on an around-the-clock basis.



The following information was obtained from a

search of the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, and is being furnished to you for your information.

The following information was obtained from a search of the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, and is being furnished to you for your information.

The following information was obtained from a search of the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, and is being furnished to you for your information.



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There are pieces of legislation which impose restrictions upon the sale of poisons by community pharmacists, but no similar provisions are made to protect the consumer who may purchase them through non-pharmacy retail outlets. It is recommended that regulations pertaining to sales of hazardous substances apply equally to all distributors, if distribution through other than pharmacy outlets is to be allowed.

DEVELOPMENT OF PHARMACY AND ITS ROLE IN MODERN CANADIAN HEALTH CARE:

Today's pharmaceutical products provide for rational and efficient therapeutics. Yesterday's drugs, used mainly to treat only the distressing physical symptoms of an illness, have been replaced by drugs designed for the treatment of specific disease conditions. The rapidity of development of new drugs is characterized by a high rate of obsolescence because of the introduction of superior medication. It is estimated that 50% of the drug products now being used were not available five years ago, and 75% of them ten years ago.

COMMERCIAL SOURCES OF DRUGS:

Today, the drug products stocked by pharmacists are produced according to standards which equal or surpass the standards laid down in official texts. Thus, the modern physician experiences all the advantages to be gained in prescribing products so standardized that consistent therapeutic results can be achieved.

Because it is the primary source of very few raw materials or substances, Canada must consider itself as being in an extremely poor strategic position relative to drug supplies in the event of any emergency







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situation. In any discussion concerning the importation of drugs, consideration must be given to any adverse effects on the Canadian employment scene, on Canadian development, and Canadian existence, generally. We wish to see a greater development of industry and to encourage pharmaceutical research development to the mutual advantage of the general public, the professional practitioner and the industrialist.

Nomenclature:

The present system of naming new drugs can result in a considerable amount of confusion in that a single entity may have at least two non-proprietary names plus one or several proprietary or brand names. Canada works in co-operation with the World Health Organization to establish and assign non-proprietary names which are given official recognition. However, because of the time lag involved in such procedures and because of the desirability of assigning names quickly, it is suggested that, where necessary, a newly established non-proprietary name might best be designated as 'pending' until such time as it is assigned by W.H.O. Further, the Association recommends that consideration be given to procedures whereby an original manufacturer who holds patents on a world-wide basis be granted the right to name the drug by a proprietary name while causing all other manufacturers to market the product under the established official name or under the originator's brand name by license.

The Canadian Pharmaceutical Association does not subscribe to, nor accept the thesis that drugs



... In any discussion concerning the importance  
of drugs, consideration must be given to any adverse  
effects on the general environment, on human  
development, and on the existence, generally, of the wish  
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#### Recommendations:

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...  
...  
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... not subscribe to, nor accept the thesis that drugs





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with the same generic name, with or without an added brand name, are necessarily therapeutic equivalents. Pharmacy practitioners have found it necessary to rely on the reputation of those manufacturers that experience has proven are deserving of their confidence. The Association recognizes this practice and will continue to urge pharmacists to observe the utmost caution before assuming the responsibility for products where there is not acceptable assurance of full quality control.

The profession of Pharmacy does not disagree with those who advocate that physicians might best prescribe drugs by their generic or common names. It is the pharmacist's duty and professional obligation to interpret the prescription of the doctor. In the absence of a physician's stated order by brand and/or manufacturer's name, the pharmacist --- and only the pharmacist --- is in a position which enables him to assume the responsibility of selecting the proper preparation, be it brand-named or non branded. He is responsible for providing drugs which, to his knowledge, are completely unimpeachable.

It would be fallacious to assume that all prescriptions or a majority of prescriptions could be written by using generic terminology. It is recommended that an extremely careful searching-out of all facts be undertaken by any persons who would advocate rules and regulations to regiment prescription writing habits of physicians and, in turn, the dispensing obligations of pharmacists in both private and institutional practice.



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brand name, and merely change the container,  
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considered by the persons who would establish rules and  
regulate the selection of drugs in the pharmacy.  
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pharmacists in both private and institutional practice.



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Tariffs and Taxes:

Tariffs and taxation represent a substantial part of the cost of Canadian medicinal preparations. Most imported drugs are subjected to tariff rates of 15% to 20% of 'fair market value'. While this taxation may enhance the creation of more extensive manufacturing procedures in Canada, it does increase the cost of medication.

The 11% federal sales tax applied against drug preparations increases the financial burden borne by the patient by an estimated \$11,000,000 annually. The Association continues to recommend that this burdensome 11% tax be removed.

The direct tax which many provinces of Canada now levy on retail sales is extended to those preparations purchased for self-medication. Through the Commission, we urge acceptance of our recommendations that all such products be properly classified as drug products and exempted from such direct retail sales taxation.

It is further recommended that the cost of purchasing needed health care be substantially alleviated by the elimination off the present 3% of net income stipulation in the Income Tax Act so that income tax relief is extended to 100% of annual personal medical expenditures.

Patents:

It is the opinion of the Association that patent protection should extend to a drug's production process regardless of its country of origin and provided, also, that in due course, but not exceeding a period of





January 1, 1954

Dear Sirs:

Reference is made to your letter of December 15, 1953.

The essential part of the cost of the goods is not subject to duty. Most imported goods are subject to duty at a rate of 10% to 15% of the value. While this taxation may enhance the cost of the goods, it does not enhance the manufacturing process in Canada. It does, however, the

The 10% duty on goods is applied

against the proportionate increase in the financial burden borne by the patient. An estimated \$11,000,000 annually. The Association continues to recognize that this burden is a tax. It is not a tax, but it is a burden.

The direct tax which may be applied

Canada now levy on retail sales is estimated to be \$11,000,000 annually. The Association continues to recognize that this burden is a tax. It is not a tax, but it is a burden. The Association continues to recognize that this burden is a tax. It is not a tax, but it is a burden.

It is further estimated that the cost

of maintaining needed health care is substantially increased by the elimination of the present 10% of net income deduction in the Income Tax Act. The income tax relief is extended to 10% of annual personal medical expenses.

It is the policy of the Association

that patients who are unable to pay for a drug's production process be relieved of the burden of the cost of the drug. It is also, that in the future, the cost of the drug be reduced.



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three years or other suitable period made necessary by the nature of the drug, it should be produced in Canadian-based manufacturing facilities. As at present, the patent holder should have the right to license other producers. Compulsory licensing provisions of the Patent Act should continue to be exercised to facilitate legal production by Canadian companies.

Research:

Major advances resulting from research are still very few in number, but applied research which improves an existing drug entity or preparation by even 10% to 20% can often mark the difference between successful and indifferent therapeutic results.

There is evidence that the volume and importance of research activities are increasing in Canada. It is to be recommended that all such activities might benefit through co-ordination by research organizations. Too, consideration should be given to the worthiness of extra tax concessions to encourage pharmaceutical research in our nation, and in this regard, the Association is pleased to note that, to some extent, such concessions were provided for in the recent federal budget.

Advertising and Promotion:

Many promotional methods are utilized by drug manufacturers and distributors. The Association has frequently recommended to manufacturers that strict control be exercised over sampling procedures and, within limits, samples carried only to those physicians and institutions who request a quantity of a preparation for experimental or investigational purposes. Direct contact



2 March 1968

three years or other suitable period made necessary by the nature of the drug, it would be possible in Canada to have manufacturing facilities. As at present, the patent holder should have the right to license other producers. Compulsory licensing provisions of the Patent Act should continue to be expanded to facilitate legal production by Canadian companies.

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### Advertising and Promotion:

Many promotional methods are utilized by drug manufacturers and distributors. The Association has frequently recommended to manufacturers that at least one sample be given to each physician and, within a certain period, samples can only to those physicians and institutions who request a quantity of a preparation for experimental or investigational purposes. Direct contact





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with physicians by field forces of company representatives provides an opportunity for discussion of matters not always appreciated from the reading of technical papers. Ideally, the 'medical detail man' should be a pharmacist but the manpower needs in this field are such that the number of pharmacists presently available is insufficient.

The association is of the opinion that pharmaceutical advertising through the medium of professional journals and direct mail pieces, exhibits and other methods of promotion can be conducted effectively with a complete absence of undesirable frills. It is recommended that advertising place emphasis upon the dissemination of factual product information and of educational facts and that they be designed so as to provide for the proper identification of the product and its usage, while stating literature references to direct attention to more complete scientific reviews. Professional associations, with outside financial support, possibly from government, might undertake a more extensive adjudication leading to the dissemination of unbiased, factual reference material concerning each and every drug preparation, but in considering such an undertaking and its vastness, it must be recognized that great reliance must be placed upon information available from manufacturers, in any event, and that there are reference texts such as the "Compendium of Pharmaceutical Specialties" published by the Canadian Pharmaceutical Association presently available at very nominal cost to all health profession practitioners.

Drug Distribution Through Wholesalers:



with physicians in field forces of country representatives  
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pharmaceutical practitioners.



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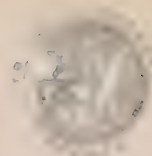
The drug wholesaler's service function is rendered to manufacturer and community distributor alike. The full-line drug wholesaler, warehousing fast turnover items in addition to slower moving pharmaceutical preparations, is best able to maintain facilities and staff and to function more economically than could be accomplished through facilities which might be expected to devote space, personnel and time to the centralized distribution of pharmaceuticals only

DRUG DISTRIBUTION THROUGH RETAIL PHARMACY:

Approximately 25% of the factory value of manufacturers' drug shipments are now directed to Canadian hospitals, with a further 12% to government and government institutions. Tabulations for 1958 indicate that in Canadian hospitals, drugs were responsible for a per patient day cost of \$0.81 or a per patient admission cost of \$9.52.

Community retail pharmacy practice is usually carried out as part of a retail business establishment. Under the conditions of a free enterprise economy, the range of the retail pharmacy's commercial undertakings has been extended but with a concurrent effort to always provide necessary professional service. The community pharmacist has a particular stake in good business policies, and contrary to some popular thinking, he has no monopoly except those which accrue from his professional responsibilities. It must be recognized that the variety of 'other merchandise' in most retail pharmacies subsidizes prescriptions and makes the availability of pharmaceutical service financially practical in all populated areas.





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... is rendered to the public and community ...  
... in addition to the ...  
... is not able to maintain facilities and staff  
... and to function more economically than could be accom-  
plished through facilities which might be expected to  
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... of ...

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pharmacist has a particular stake in good business  
policy, and contrary to some popular thinking, he has no  
more to extend than the other professional  
responsibilities. It is to be recognized that the variety  
of "business" in retail pharmacy is not a  
precondition and hence the availability of pharmaceutical  
service is not a precondition in all acquired areas.



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Limitation to professional service items might be desirable but is impractical in our free enterprise system.

Using D.B.S. figures of December 1958 in which it is stated that 2.43¢ of the consumer dollar was spent in Canadian pharmacies, it may be calculated that prescription services take up about 3/5 of 1¢ of the consumer's buying dollar. Per capita expenditure on prescriptions during 1960 amounted to \$7.36.

Prescription pricing methods vary to a degree across Canada. Under the most common method in existence in Canada today, the final prescription price is based on the retail list price of the drug to which is added a nominal dispensing fee. Thus, the pharmacist's professional remuneration is composed of the normal commercial mark-up and a fee. There is an increasing feeling that this present method should be abandoned in favour of applying a constant professional fee to the pharmacist's cost of the drug. The pricing of prescription services merits further study.

The pharmacist's primary responsibility to his community is to render a complete and immediate prescription service. A prescription is not an ordinary item of commerce. It is the end result of pharmaceutical services ordered for a specific patient by a medical or dental practitioner. The pharmacist must often contact the physician concerning prescriptions as written, or concerning the refilling of previously written prescriptions. This is a most important area of personal professional activity. The assumption of the ethical, moral and legal responsibilities cannot be costed, nor can

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they be related to the mere purchase of a commodity at a retail price.

In spite of the tendency for individually licensed personnel to remain in urban areas, there are very few villages and towns across Canada without community pharmacy service. In direct contrast to any merchandising trend is the appearance of an increasing number of so-named 'prescription specialty pharmacies' in locations where there is a high concentration of medical practitioners.

It would be quite improper to assume that prescription service provided by the most prevalent type of pharmacist-owned retail pharmacy is necessarily inferior in any manner to that provided by a prescription specialty pharmacy. The Association is of the firm opinion that the quality of the prescription service that is being provided by Canadian pharmacists is high.

#### DRUG DISTRIBUTION THROUGH HOSPITAL PHARMACIES:

More extensive drug treatment of ambulatory patients enables hospitals to care for a greater number of patients who definitely require hospitalization. To keep the period of hospital utilization per patient to an essential minimum it is rational to recommend that drugs required for a certain definite outpatient period might well be provided for through the pharmacist of the patient's choice, in keeping with his personal, private desires.

Comparisons between the price of drugs purchased from a retail pharmacy and the price for the same drugs by a hospital are completely unrealistic as they do not properly relate to various purchase levels or conditions under which such drugs are made available to the patient.



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2 they be related to the type of service or a community of  
3 retail prices.

4 a series of the tendency for individual

5 licenses, personnel to retail in their areas, there are  
6 very few villages and towns a loss of retail without community  
7 pharmacy service. In these areas the very much increasing  
8 trend is the appearance of an increasing number of  
9 retail 'one-stop' stores, often in locations  
10 where there is a high concentration of retail establishments.  
11 It would be quite proper to assume

12 that description service, now in the local level  
13 type of pharmacist-owned retail pharmacy is necessary  
14 inferior in any manner to that provided by a prescription  
15 specialty pharmacy. The Association is of the firm opinion  
16 that the quality of

17 pharmacy service is a high

18 the extensive long-term commitment of  
19 community pharmacy enables patients to have a greater  
20 number of patients who are likely to have hospitalization  
21 to keep the quality of service high and the patient to  
22 an essential minimum it is intended to have well paid  
23 drugs required for a certain number of certain patients  
24 might well be provided for to ensure the standard of the  
25 patient's choice, in keeping with the personal, private

26 Governmental action is needed to

27 proposed from a retail pharmacy and the retail pharmacy  
28 some form of a retail pharmacy and community pharmacy  
29 may be not properly relate to various pharmacy levels, or  
30 conditions which may be met and the quality of the



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It must be assumed that consumer prices subsidize, directly or indirectly, the price at which the same drugs are offered to hospitals, institutions and government departments. The problem of multiple levels of pricing and price discount policies as such relate to various purchasing levels has long been recognized by the association which has made known to manufacturers its statement of policy that "The principle of equal price for equal quantity and equal quality, provided that there is a reasonable and equitable relationship between quantity price levels, is the only principle which should guide pricing policies in the distribution of drugs to all purchasing levels".

While the Association fully endorses the Standards of Accreditation of Canadian Hospitals concerning hospital pharmacy, it does seriously question the propriety of permitting accreditation of a hospital under the alternative of "...competent supervision..." by other than a pharmacist when proper safeguarding of the patient under all circumstances and conditions must be the criterion. The Association strongly recommends that each province takes steps to ensure as safe a practice of Pharmacy for its hospitals and rest homes and other health institutions as is provided in retail pharmacies through the statutory requirements that drugs be distributed under the supervision of a qualified pharmacist.

It is recommended that every hospital of 75 beds or over maintain full time pharmacist-supervised services and that smaller hospitals and similar institutions be required to arrange for part time pharmacist





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It is not a simple matter to compare prices

The same of the way of doing business, institutions  
and government organizations, the fact of multiple  
levels of pricing and price differentials as well  
relative to what is purchased. This is the long term  
and gained by the association with the same known to  
confrontations the statement of policy that "The principle  
of equal price for equal quality and equal quantity."  
One fact that there is a reasonable and equitable relation  
ship between quantity and price, is the only principle  
which would guide our policy in the distribution  
of things to all purchasing levels.

While the association fully understands

the importance of the addition of tax to the hospital  
of certain financial matters, it does emphatically object  
to the principle of purchasing association of a hospital  
where the alternative of "...concerning supervision..." by  
itself is a characteristic when the responsibility of the  
patient under all circumstances and conditions that is the  
association. The association supports a principle that  
as a country's taxes are to be used as a sale of the  
of the country for the hospital and the other and other  
health institutions as is required in retail pharmacies  
through a voluntary arrangement that there be no difference  
when the association of a hospital is concerned,  
it is the principle that a new association  
is to be made by the hospital for the same reason and  
that the same principle should be applied to all hospitals  
there is required to be applied for the same reason.



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supervision either on a regional basis or by a direct agreement with a community pharmacist, or otherwise. Regardless of the size of a community hospital or similar patient care institution, there is a nearby, properly staffed community retail pharmacy and thus, adequate supervision can be given by the local pharmacist through utilization, on a partial time basis, of his services.

Further, the Association recommends the adoption of the Minimum Standard for Hospital Pharmacy in Canada as approved by the Canadian Society of Hospital Pharmacists and its use by all agencies which are charged with the responsibility of evaluation and implementation of hospital services.

In many provinces, provincial hospital care programs have not given evidence of sufficient concern with standards of hospital pharmaceutical services and many have failed to retain, at the policy-making and administrative levels of such organizations, the services of competent pharmacists. The employment of pharmacists in advisory, administrative and practising capacities is most essential for the proper interpretation and full implementation of all standards pertaining to drugs.

#### OTHER SOURCES OF DRUG SERVICES:

Under existing legislation, persons other than pharmacists may have a financial interest in a pharmacy under certain conditions. Except where local needs dictate, the principle of the joint practice of medicine and pharmacy is considered to be not in the best interest of the patient, nor is the financial involvement of a medical practitioner in a pharmacy or a manufacturing and/or distributing company viewed with favour. The



supervision either on a regular basis or by a direct assessment with a community pharmacist, or otherwise. Regular use of the size of a community hospital or similar patient care institution, there is a ready, properly staffed community retail pharmacy and thus, adequate supervision can be given by the local pharmacist through utilization, on a part-time basis, of his services.

Further, the Association recommends the adoption of the Joint Standards for Hospital Pharmacy in Canada as approved by the Canadian Society of Hospital Pharmacists and its use by all agencies which are charged with the responsibility of evaluation and implementation of hospital services.

In many provinces, provincial hospital drug programs have not given evidence of sufficient concern with standards of hospital pharmaceutical services and many have failed to realize, as one policy-making and administrative levels of such organizations, the services of hospital pharmacists. The expansion of pharmacists in advisory, administrative and practical capacities is most essential for the proper interpretation and full implementation of all standards pertaining to drugs.

#### Joint Standards for Drug Services:

Under existing legislation, persons other than pharmacists may have a financial interest in a pharmacy and certain conditions exist where local needs dictate, the principle of the joint practice of medicine and pharmacy is considered to be not in the best interest of the patient, nor is the financial involvement of a medical practitioner in a pharmacy or a manufacturing pharmacy a desirable one. With a view to the





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Association is of the firm opinion that the practice of Pharmacy should not be allowed to be subjected to the influences of disinterested persons such as non-pharmacist owners or corporate members in a business enterprise.

Most health insurance policies now available include co-insurance and deductible clauses. Payment is by reimbursement and all too often the necessary documentation requires the divulging of information which violates the confidential nature of the medical and prescription services. This highly improper kind of documentation, where it exists, is opposed by the profession.

#### PRESENT COSTS OF PHARMACEUTICAL SERVICES:

It would be a misconception of economic facts to regard the prescription department of the retail pharmacy in isolation from the total business operation. It is admitted that the professional capacities of pharmacists to dispense prescriptions are less than fully utilized in many community pharmacies, but it is emphasized that this situation does not add to the price that the public assumes for each service.

#### Prescription Prices:

There are possibly two basic questions foremost in the minds of those to whom pharmaceutical services are rendered and to those who are confronted with the task of economic reviews designed to provide information which will permit the formulation of a program to provide for health care services:

- (1) Why has the average price per prescription increased over the years?





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- (a) Inflation in Consumer Price Index
- (b) Inflation in wage rates
- (c) Quantity within each prescription has increased
- (d) Cost of ingredients
- (e) Federal sales tax on ingredients increased from 3% to 10% to 11% between 1951 and 1958
- (f) More chronic, ambulatory treatment with a concentration of specific disease categories in hospitals
- (g) Expenses generally, and the remuneration of persons who render professional services have increased (108.8% expenses versus 67.7% gross sales increase, 1952-1960).
- (h) Physicians and patients, alike, expect more from today's specificity in drug therapy than in the past, with the consequent concentration on this aspect of health services.

(2) Why has the ratio of prescription revenue to gross sales in retail pharmacies increased over the years?

- (a) More prescriptions dispensed (38.4% increase, 1951-1960); higher utilization (2.2. to 2.41 prescriptions)
- (b) The average prescription price has increased (\$1.68 to \$3.06).
- (c) Traditional non-prescription sales are now shared more with non-pharmacy





(a) Inflation in Consumer Prices Index

(b) Inflation in Wage Rates

(c) Inflation in each principal business

(d) Cost of Inflation

(e) General Sales Tax on Inflation

increased from 38 to 100 to 100 between

1981 and 1982

(f) Core Chronic, curative treatment with

a concentration of specific diseases

categories in hospitals

(g) Expenses generally, and the remuneration

of persons who render professional

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es versus 67.7% gross sales increase,

(h) Physical and patients, alone, expect

more from today's scientific in drug

therapy than in the past, with the con-

sequent concentration on this sector

of health services.

(i) What has the role of prescription revenue to gross

sales in retail pharmacies increased over the period?

(j) Some pharmaceuticals decreased (33.4%)

tion (2.2% to 2.41 prescriptions)

(k) The average prescription price has

increased (41.50 to 42.00)

(l) Addition of non-prescription sales

now associated with pharmacy



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- outlets, thus proportionately lowering the gross sales of retail pharmacies.
- (d) The ratio of population (increased by 4,000,000) per pharmacy has increased (one per 3,441 in 1951, one per 3,624 in 1960).
- (e) Increased proportion and greater urban population with resultant urban convenience and accessibility to pharmacies and other health care facilities (1957- general population prescription expenditures \$6.22 per capita, while urban population expended \$3.15)
- (f) More health dollars available as a consequence of various health schemes.
- (g) A generally improved standard of living and health, and a desire to maintain same
- (h) Increased proportion of population in the under 15 year and over 75 year age categories.
- (i) Physicians' services more accessible (one for every 970.4 persons in 1956, one per 881.9 in 1960).

Prescription Costs in Perspective:

Although opinions have been expressed that Canadian drug prices are the "highest in the world", such a statement applied to the average prescription is not borne out by statistics which, over the years, show that the average prescription prices in Canada are



outlet, such proportion any lowering  
the cost, sales of retail, facilities,

(d) The ratio of population (increased)

by 4,000,000 per pharmacy has increased

(one per 3,447 in 1931, one per 3,624

in 1950).

(e) Increased proportion and greater urban

population with resultant urban con-

venience and accessibility to pharmacies

and other health care facilities (1937

General population prescription expan-

sion 26.32 per capita, while urban

(f) More health facilities available as a

consequence of various health services.

(g) A generally improved standard of living

and health, and a desire to maintain

(h) Increased proportion of population in

the under 15 year and over 75 year age

categories.

i) Physiological factors more accessible

(one for every 300 persons in 1938,

one per 219 in 1950).

### Prescription Costs in Canada

Although all these have been increased

that Canada an drug prices are the "highest in the world",

such a statement applied to the average prescription is

not borne out by statistics which, over the years, show

that the average prescription prices in Canada are





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considerably less than those of, for example, the United States (\$3.06 and \$3.19, respectively, in 1960).

Increases in drug costs have not been out of proportion to increases in the prices of other services and commodities in Canada. Prices in general, according to D.B.S., increased 28.0% between 1949 and 1960, while the price of drugs experienced an increase of 27.3%.

Similarly, per capita expenditures upon drug services compared to money expended to utilize many other services and commodities are exceedingly low.

Available statistics indicate that prescription drugs remained a constant 12% of health care expenditures during the four-year period, 1953-1957.

High priced prescriptions are the exception rather than the rule. A 1957 Canadian survey (Appendix K), showed that 58.5% of all prescriptions were dispensed at a price of \$2.50 or less and that only 1.1% were priced at \$10.00 or more. These figures are generally confirmed in recent surveys. Today, the daily cost of the average prescription averaged over the period of time in which it will be consumed, is only 21.7¢.

The Association is very aware that the financing of prescription services may be burdensome to persons with very limited means and for those who suffer from conditions requiring vast amounts of medication over extended periods of time. It firmly believes, however, that drug costs for the vast majority of Canadians are neither exorbitant nor high.

PRESENT METHODS OF PROVIDING PHARMACEUTICAL SERVICES TO PERSONS IN NEED:





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There appears to be no standard method of determining need, no standard criteria as to what may or may not be supplied, and no standard acceptance of responsibility by any particular level of government. It would, therefore, seem most proper to recommend that federal and provincial levels of government assume joint financial responsibility for providing health care services to those who are in need and unable, themselves, to pay for such services. Further, it is recommended that there be established a guiding minimum, nation-wide standard of care and/or level of service to ensure that similar benefits are available in all areas of Canada. Also, the assumption of full responsibility on behalf of such individuals should encompass those 'medical indigents' whose needs may be presently assumed by service organizations.

In virtually all present cases of supplying drugs and pharmaceutical services to indigents, the pharmacists, either individually or collectively through their associations, grant a discount from normal prescription price and thus, the provision of these welfare services is shared jointly by governments and pharmacists. Such discounts could not be considered as economically feasible in any comprehensive system of supplying pharmaceutical services to the general public.

MANPOWER:

The records of the Association as of June 30, 1961 indicate a membership total of 8,940 registered pharmacists employed in the many areas of pharmaceutical endeavour in Canada.





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These aspects are not to be overlooked.

of its existing need, no standard objective as to what may  
or may not be considered, in the standard objective of  
responsibility for any particular level of government. It  
should, therefore, seem most proper to say that the  
Federal and provincial levels of government should have joint  
responsibility for the health care system.  
As to those who are in need and unable, themselves,  
to pay for such services. Further, it is recommended  
that there be established a national commission, action-wide  
standard of care and/or level of service to ensure that  
similar benefits are available in all areas of Canada.  
Also, the responsibility of all responsibility on behalf of  
such in this case should encompass those "indigent" patients  
whose needs may be met only assisted by service organiza-  
tions.

In virtually all present cases of  
supplying drug and pharmaceutical services to indigents,  
the pharmaceutical, either individually or collectively  
from their associations, grant a discount from normal  
prescription price and thus, the provision of these services  
is shared jointly by governments and pharmaceuticals.  
Such discounts could not be considered as economically  
feasible in any comprehensive system of supplying pharmaceutical  
services to the general public.

#### Recommendations

The results of the investigation are as follows:  
1. To create a national commission, action-wide  
standard of care and/or level of service to ensure that  
similar benefits are available in all areas of Canada.



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In 1960, Canada's eight Colleges of Pharmacy graduated 264 pharmacists and it is not improbable that when more complete manpower statistics become available, this figure will be found to be below the annual total loss from death and retirement.

Canada, on the average, has one community retail pharmacy to serve the needs of 3,672 persons. In 1959, 674 of Canada's 4,881 pharmacies were located in 514 urban centres. It is possible that a disproportionate distribution of pharmacies exists and it may be that Pharmacy should strive to redistribute outlets and personnel.

In Canada's hospitals, if salary schedules and career opportunities are hindering the obtaining of pharmacists, correcting measures should be taken immediately. Where provincial legislation does not now require the mandatory licensing of persons employed as pharmacists in hospitals, legislatures should demand that Pharmacy Acts be immediately amended to provide for such professional registration of all pharmacy practitioners.

There is a backlog of unfilled positions for pharmacists in government service including the armed forces. Salary schedules and professional career advancement opportunities must meet or surpass those available in private practice to properly influence the acquisition of pharmacists classified as such within the Civil Service to meet the full needs of government.

#### PHARMACEUTICAL EDUCATION IN CANADA:

The modern study of Pharmacy may now be



at 1950, Canada's eight Colleges of

Pharmacy graduated 104 pharmacists and it is not impossible that when more complete pharmacy statistics become available, this figure will be found to be below the annual total loss from death and retirement.

Canada, on the other hand, is the

community retail pharmacy to serve the needs of 3,644 persons. In 1950, 67% of Canada's 4,541 pharmacists were located in the urban centers. It is possible that a disproportionate distribution of pharmacists exists and it may be that Pharmacy should strive to redistribute outside and personnel.

In Canada's efforts, it is

services and career opportunities are offering the opportunity of pharmacists, correcting measures should be taken immediately. Where a critical regulation does not now require the pharmacy is a source of persons employed as pharmacists in hospitals, laboratories and in the community pharmacy was the pharmacy's emphasis to provide for such professional regulation of all pharmacy personnel.

There is a shortage of staff in

times for pharmacists in government service including the armed forces. Early selection and process and career advancement opportunities must be developed to ensure the availability of personnel to meet the present and future needs of the various branches of the government.

Pharmacy in the future

The present situation of pharmacy may not be





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viewed as an academic discipline with certain non-professional studies being an essential part of the preparation of the pharmacist. There are eight colleges, schools or faculties of Pharmacy in Canada established within a university, one in each of the Provinces of British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario, two in Quebec and one in the Maritime Provinces. The degree awarded is that of Bachelor of Science in Pharmacy.

Recently, Dalhousie University absorbed the Maritime College of Pharmacy and has established a College of Pharmacy in its Faculty of Health Professions. The budget, as jointly provided by the university and the provincial professional societies, will only be adequate for the needs of the immediate future. We recommend, therefore, that in the interest of providing in this area of Canada, pharmaceutical training on a par with all other provinces and states in this continent, necessary financial support, made available from government sources, be regarded as a matter of urgency.

Continuing Education:

The pace at which the medical and pharmaceutical sciences are forging ahead has rendered almost obsolete the informal approach of licensing bodies and teaching faculties to refresher course work and extension programs. Universities are organizing their extension services to provide for continuing education in many fields and it is recommended that Pharmacy faculties be assisted with the necessary funds to establish, on a full-fledged departmental basis, a well-rounded program of continuing education for practising pharmacists.



viewed as an essential part of the education of the pharmacist, there are also some facilities of pharmacy in the various provinces. In fact, one is found in the province of Ontario, Ontario, Alberta, Saskatchewan, and Manitoba. Two in Quebec and one in the Maritime Provinces. The degree awarded is that of Bachelor of Science in Pharmacy.

Recently, however, university education in the Maritime Provinces of Canada has been obtained a college of pharmacy in the Faculty of Health Sciences. The degree is jointly provided by the university and the provincial professional societies of a number of states for the purpose of the immediate future. We therefore, therefore, that in the interest of providing in this area of Canada, pharmaceutical training on a par with all other provinces and states in this country, presently.

is regarded as a matter of urgency.

#### Continuing Education:

The pace at which the national and international sciences are forcing a new tempo upon us, and the rapid expansion of knowledge in the various fields of science and technology, has created a need for continuing education in the pharmaceutical field. The pharmaceutical industry is a dynamic one and it is imperative that the pharmaceutical industry should be assisted with a new and more effective method of continuing education. The pharmaceutical industry is a well-known and a well-respected one, and it is a well-known fact that the pharmaceutical industry is a well-known and a well-respected one, and it is a well-known fact that the pharmaceutical industry is a well-known and a well-respected one.



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Graduate Education and Research:

Although Canadian Pharmacy colleges have made important advances in the areas of graduate study and research, they have not been able to keep pace with the demand for advanced study. It is recommended that the Commission endorse the allotment of extraordinary federal grants for the further development of advanced study in Pharmacy and the other health sciences.

A STATEMENT OF POLICY OF THE CANADIAN PHARMACEUTICAL ASSOCIATION RELATIVE TO HEALTH INSURANCE PLANS:

The Problem: The Pharmacists of Canada are of the opinion that there are issues in the whole field of the provision of health care services which require examination. During recent years the cost of modern health services has risen to a point where a significant number of Canadian families may be financially unable to meet the cost of a major illness. In recognition of this, governments in Canada have introduced a form of universal hospital insurance. However, the remaining elements of health care, including pharmaceutical services, may still present a financial problem to a portion of the population of Canada.

Acceptable Solutions: The profession of Pharmacy recognizes the existing deficiencies. It is of the opinion that governments can provide legislation to correct the situation through the expansion and extension of existing voluntary health insurance plans. Should study prove conclusively that it is not practical to provide an adequate standard of comprehensive health care by modification of existing plans, the profession of Pharmacy is





At the same time, it is necessary to

have some important evidence in the case of the  
state and research, then we not only have to keep pace  
with the demand for development, it is necessary

that the Commission should also be interested in extraordinary  
factors which are the result of advanced  
study in science and the other health sciences.

THE COMMISSION ON THE HEALTH OF CANADA

The Commission on the Health of Canada is one of the  
agencies that have been created in the whole field of the  
provision of health care services which require extensive  
study, planning and action, the work of health

services has been to a point where a significant number  
of agencies, which have been in the field, are able to meet  
the need of a state or province, in recognition of this,

government in Canada have developed a new or a different  
health services. However, the remaining elements of  
health care, including pharmaceutical services, and still  
present a financial problem to a large part of the population  
of Canada.

Health Services in Canada The problem of health

services is the existing relationship between the

that have been created and the need for health services

situation that is the result of the existence of various

which are health insurance plans, which are to provide

consequently there is a need for action to provide an

effective system of health services and to provide

that an existing system, the necessary to "ensure



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prepared to accept, in principle, an alternative government sponsored comprehensive plan.

Pharmaceutical Benefits:

The Canadian Pharmaceutical Association considers any health care plan to be comprehensive only if it includes pharmaceutical services, provided by pharmacists, among its benefits. In the interests of the patient, pharmaceutical benefits should be in the form of services rather than reimbursement.

Compulsory Features:

Pharmacy expresses the view that the idea of compulsion is basically distasteful but realizes that the achievement of universal coverage is most desirable in the financing of any health care program. Nothing, economic or otherwise, in any scheme should be incompatible with high standards of service or interfere with the relationship which presently exists between patient, physician, pharmacist, and other members of the health professions. It should also safeguard the democratic rights of those who do not wish to receive its benefits.

Principles in Respect to Pharmaceutical Benefits:

Without limiting in any way the generality of the foregoing statements, the Canadian Pharmaceutical Association states that to be acceptable to the pharmacists of Canada, any comprehensive health care plan must observe the following fundamental principles in respect to pharmaceutical benefits:

- (i) Such plans shall recognize existing federal and provincial legislation



properly to be done, in order to be able to make a proper  
assessment of the situation.

The first thing that must be done is to make a  
comprehensive study of the situation, taking into account  
it is not only the patient's condition, but also the  
physician, the pharmacist, the nurse, the pharmacist,  
the patient, the pharmacist, the nurse, the pharmacist,  
the patient, the pharmacist, the nurse, the pharmacist.

It is not enough to have a good idea of the situation,  
it is also necessary to have a good idea of the situation,  
that the situation is basically different and requires  
different treatment of universal coverage in the  
different areas of the health care system.  
Nothing, economic or otherwise, in any sense should be  
incompatible with high standards of service or interfere  
with the relationship which properly exists between  
patient, physician, pharmacist, and other members of the  
health care team. It should also be understood that  
democratic rights of those who do not wish to receive the

Pharmaceutical Association of Canada  
without limitation in any way the  
Government of the Province of Ontario, the Canadian  
Pharmaceutical Association or the right to be able to  
to the pharmacist or nurse, and comprehensive health  
care plan must observe the following principles:  
which in respect to pharmaceutical benefits  
such plans shall be subject to the following  
conditions and shall be subject to the following





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concerning Pharmacy and/or drugs and nothing in these plans shall contravene such legislation.

(ii) Drugs and all pharmaceutical services shall be supplied directly to the public only by pharmacists through legally authorized and regulated retail pharmacies of the province concerned. In hospitals, the supplying of drugs and related professional services shall be limited to bona fide hospital patients.

(iii) The profession of Pharmacy shall have direct representation on any body charged with the initiation and development of policies pertaining to pharmaceutical services. Pharmacists shall be directly involved in the administration of such policies.

(iv) The patient shall be free to obtain pharmaceutical services from the pharmacist of his choice.

(v) A pharmacist shall be free to conduct his practice, or any part thereof, outside of such health care plan if he so chooses.

(vi) Benefits shall include any and all drugs considered necessary by the authorized prescriber for the welfare of the patient, as well as specified therapeutic devices. The only restrictions on prescribing shall be in terms of



occasionally, the law and of the fact  
noting that the law shall continue  
from 1914 to 1915.

There and a 1915 amendment to the  
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quantity for any single prescription  
and the number of times it may be  
repeated.

(vii) While this Association does not look  
with favour upon the use of deterrents,  
the fact must be faced that it has been  
necessary to introduce controls on  
pharmaceutical benefits in every major  
health care plan on which data are  
readily available. Rather than intro-  
duce restrictions in undesirable stages,  
such controls as might seem advisable  
should be introduced at the beginning  
of a health care plan so that there may  
be a possible reduction of restrictions  
at a future time.

(viii) Members of the profession of Pharmacy  
shall have the right to determine the  
basis of their remuneration for profes-  
sional services as distinct from payment  
for materials involved in the rendering  
of pharmaceutical services. The amount  
and manner of such remuneration for  
both professional services and materials  
shall be a matter of negotiation from  
time to time to reflect changes in  
economic conditions.

METHODS OF PROVIDING PHARMACEUTICAL SERVICES IN HEALTH  
CARE PROGRAMS:

By way of summary, it is sufficient to





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state that none of the existing methods of providing pharmaceutical services within any of the existing health insurance programs in Canada meets all of the principles off the Association's Statement of Policy Relative to Health Insurance Plans. One program only, Prescription Services, Inc.; (Green Shield) of Windsor, Ontario, which deals specifically with pharmaceutical services, closely approximates the logic expressed in the Association's Statement of Policy.

ESTIMATED COST OF PROVIDING PHARMACEUTICAL SERVICES IN A COMPREHENSIVE HEALTH CARE PROGRAM:

The development of cost estimates by the projection of present figures related to the provision of pharmaceutical services requires caution because utilization of services will increase under a program which eliminates any economic barrier and/or natural reluctance towards the assumption of the cost of such services.

Recommendations Relative to a Canadian Program:

Whether it be an extension of an existing voluntary program or an entirely new program under government sponsorship, certain priorities might well be considered in instituting a health care plan for Canadians. These are presented on the assumption that a plan will be introduced in stages, but in keeping with the principles outlined in the Association's Statement of Policy.

- (1) Removal of Federal Sales Tax from prescription medication and therapeutic appliances;
- (2) Income tax relief relative to total personal health care expenditure by removal of present 3% of net income clause;







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- (3) Provision for all drug services required by hospital patients;
- (4) Provision for all drug services required by welfare recipients;
- (5) Provision for all drug services required by 'medical indigents';
- (6) Provision for drug services required for patients with chronic or long-term illnesses;
- (7) Provision for drug services required to meet catastrophic situations of illnesses or accidents;
- (8) Provision for drug services by certain illness or disease categories;
- (9) Provision for certain therapeutic classifications of drugs;
- (10) Provision for drug services required by age groups;
- (11) Provision for certain drug services required by all residents;
- (12) Provision for all drug services required by all residents.

Financing:

The Association does not feel it to be within its scope to make recommendations on methods of financing an all-embracing program of health care insurance which might be introduced in Canada other than to make observations as a member of the Canadian community. It is presumed that financing will be met, to some extent, from public funds with responsibility shared by federal and provincial governments, possibly in a manner not unlike that pertaining to the proportionate sharing relative to current hospital services programs. It is also presumed



(1) Provision for all drug services required in hospital

patients;

(2) Provision for all drug services required by welfare

patients;

(3) Provision for all drug services required by medical

inpatients;

(4) Provision for drug services required for patients with

acute or long-term illness;

(5) Provision for drug services required to meet other

specific situations of illnesses or accidents;

(6) Provision for drug services by certain illness or

disease categories;

(7) Provision for certain therapeutic classifications of

drugs;

(8) Provision for drug services required by age, notes;

(9) Provision for certain drug services required by all

residents;

(10) Provision for all drug services required by all

Financing:

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warranted to enter into recommendations on methods of

financing an all-embracing program of health care insurance

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provincial governments, possibly in a manner not unlike

that pertaining to the proportionate sharing relative to

current hospital services programs. It is also possible



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that premiums voluntarily paid by those who wish to be beneficiaries under the plan will constitute a substantial portion of the program's fund. Patient participation through the payment of a portion of the fee for service at the time service is rendered will assume part of the overall total health care cost which, in addition to the practitioner's remuneration, will include the cost of administration.

The Association's Annual Survey of Retail Pharmacy Operations for 1960 (Appendix P) shows that, based on averages for the population as a whole, each individual in Canada received 2.37 prescriptions dispensed for him at a cost of \$3.06 each for a total yearly expenditure of approximately \$7.26 per capita. However, from various published estimates it can be determined that during 1960 Canada experienced a utilization rate of approximately 3.2 prescribed drug services per capita. It must be assumed that in a health care insurance program, Canada's prescription utilization might conceivably rise to 5.0 per capita and that inflationary trends and other factors might increase the average price to some \$3.30 for a per capita cost of \$16.50.

The Canadian Pharmaceutical Association would speculate that a program designed to provide for the financial requirements of all-embracing comprehensive pharmaceutical services would cost between \$16.50 and \$19.00 per person per year and, if utilized by the whole of the population of Canada, total costs would be in the \$300,000,000 to \$360,000,000 range in its initial year of





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portion of the program's... present participation  
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practitioner's remuneration, which includes the cost of

The Association's Annual Survey of  
Retail Pharmacy Operations for Last Year (1966) shows  
that, based on averages for the population as a whole,  
each individual in Canada received 2.84 prescriptions  
of which for him at a cost of \$3.16 each for a total  
yearly expenditure of approximately \$1.30 per capita.  
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determined that during 1966 Canada's expenditure on  
utilization rate of approximately 8.2 prescriptions only  
services per capita. It must be assumed that in a health

might conceivably rise to 8.0 per capita and that  
inflationary trends and other factors might increase the  
average price to some \$3.30 for a per capita cost of

The Canadian Pharmaceutical Association  
would appreciate that a program designed to provide for the  
financial requirements of all-encompassing comprehensive  
pharmaceutical services would cost between \$1.00 and  
\$1.10 per person per year and, if utilized by the whole  
of the population of Canada, total costs would be in the  
range of \$100,000,000 to \$120,000,000 in the initial year of



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operation. Future costs must be expected to increase with population, prices generally, cost of living influences and wage structures.

On behalf of its members - the pharmacists of Canada, licensed under provincial statutes the Canadian Pharmaceutical Association states the profession's desire and willingness to work in full co-operation in all measures designed to better health and welfare and the method whereby they are made available to Canadians.

We welcome and appreciate this opportunity of presenting Canadian Pharmacy before this Royal Commission on Health Services.







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4 THE ACTING CHAIRMAN: Thank you very  
much, Mr. Turnbull.

5 As we indicated, discussed this  
6 morning, the questions of the Commissioners may be  
7 directed to your group, Dr. Huston, or to yours, Mr.  
8 Mitchell, and I would like any of those present here  
9 to feel free to interject or comment on any statement which  
10 may be made by any other person. Dr. Matthews can  
11 comment on his submissions with the one hat on and then  
12 with the other hat on.

13 COMMISSIONER FIRESTONE: Perhaps, Mr.  
14 Chairman, I may address my initial questions to Dr.  
15 Huston on the basis of the brief we have heard this  
morning.

16 In looking through your recommendations,  
17 Dr. Huston, one thing that impressed me was your  
18 emphasis on expanding the educational facilities in  
19 Canada, provide expanding teaching facilities  
20 and expanding opportunities for young people to enter  
21 the profession, and you have a number of recommendations  
22 in the direction of increased financial assistance from  
the federal government for such educational purposes.

23 I understand in reading over the brief  
24 of the Canadian Pharmaceutical Association that they  
25 also feel a great deal more assistance is required.

26 My question to you, sir, is I find  
27 you have four specific recommendations for increased  
28 financial assistance. The first one is to expand the  
29 university facilities in this field, and I am referring  
30 to what you have to say in paragraph 106. Then you have



THE AGING CHAIRMAN: Thank you very

As we indicated, discussed this

morning, the questions of the Commissioners may be  
directed to your group, Dr. Huston, or to yours, Mr.  
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financial assistance. The first one is to expand the

university facilities in this field, and I am referring

to what you have to say in paragraph 10. Then you have



Huston

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4 proposals for increased availability of scholarships,  
5 fellowships, bursaries, the students in pharmacy, both  
6 undergraduate and graduate, and you cover this in  
7 paragraph 106. Then you have proposals for increased  
8 grants for research and teaching in pharmacy, and that  
9 is covered in paragraph 185 to 187.

10 Have you, sir, a specific proposal  
11 to offer to this Commission which you may be prepared  
12 to endorse or modify which would indicate the amount  
13 of financial assistance you would like the federal  
14 government to provide for the expansion of pharmaceutical  
15 teaching facilities and educational opportunities for  
16 young people to enter this profession, covering the four  
17 areas I have indicated?

18 DEAN HUSTON: Not with regard to  
19 specific quantities, sir. I have made the point that  
20 we are integral within the universities and pharmacy  
21 colleges would share as an integral division with the  
22 universities. So that the proportion of funds to be  
23 used for pharmacy development would be proportionate  
24 with the demand of any particular university. For that  
25 reason I have not made specific recommendations dollar-  
26 wise with regard to pharmaceutical development.

27 COMMISSIONER FIRESTONE: You understand  
28 we are trying to establish the requirements of an  
29 expanded educational program in the field of health  
30 personnel, and that covers doctors, dentists, pharmacists.  
If we are to offer the Canadian Government some advice  
on what such an expanded program must be, presumably  
such a program should be made up of component parts:





...for increased availability of opportunities,  
...the student in pharmacy, both  
...and the state, and you know this is  
...Then you have proposals for increases  
...for research and teaching in pharmacy, and this  
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...program that we, essentially  
...program should be made up of government funds.



Huston

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4 What do you do to expand the medical faculties, what  
5 do you do for the students, what do you do for the  
6 dental profession, what do you do for the pharmaceutical  
7 profession? If one wants to arrive at an overall  
8 recommendation one has to make it up of component parts.  
9 If we just have the recommendation, please give more  
10 monies to the universities -- I am not sure that this  
11 recommendation falls within the terms of reference of  
12 this Commission -- we are concerned with health pro-  
13 fessions, of which the pharmacists are an important  
14 sector. Realizing you have not gone into this amount  
15 of detail so far, I am just wondering whether it would  
16 be too difficult a task or too strenuous a request to  
17 make to you and your associates to give some further  
18 consideration to this matter and look at the future  
19 requirements as you see them, on the teaching side, on  
20 the undergraduate side, and so on, and say in order  
21 to have the program we want it should be of this order  
22 and it should be broken down into these categories in  
23 the next five or ten years.

24 Would it be possible for you and  
25 your associates to do this, and if you have any  
26 recommendations to make to give it in writing to the  
27 secretary?

28 DEAN HUSTON: Yes, I would be prepared  
29 to do that. I could contact the various colleges and  
30 get what they feel would be appropriate for their  
colleges and get such a compilation given to you. The  
difficulty is that in universities, as you know, funds  
come from many sources, and it might be difficult to



What is your job to expand the medical facilities, what  
do you do for the students, what do you do for the  
medical profession, what do you do for the pharmaceutical

profession? It one wants to arrive at an overall  
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Now we just have the recommendation, please give more  
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the undergraduate side, and so on, and say in order  
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the next five or ten years.

Would it be possible for you and  
your associates to do this, and if you have any  
recommendations to make to give it in writing to the  
Commission?

LEAH H. STON: Yes, I would be prepared  
to do that. I could contact the various colleges and  
ask them what they would be doing for the  
future and get such a compilation given to you. The  
difficulty is that in various times, as you know, things  
come from many sources, and it might be difficult to





Huston

11400

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3 estimate what might be available in any one university,  
4 from provincial funds, from research grants, institutions  
5 and so forth. But I could certainly provide you with  
6 an overall picture with possibly some comments as to  
7 the various sources of funds. We would be prepared to  
8 do this, sir.

9 COMMISSIONER FIRESTONE: This is a  
10 very helpful observation from you, sir. I would hope  
11 that you would end up by making a suggestion of the  
12 contribution you would expect from the Federal Government,  
13 and you might end up by saying in the light of these  
14 requirements we feel that such assistance from the  
15 Federal Government would be desirable to train the  
16 specific number of pharmacists we feel are needed in the  
next ten years? Would that be possible?

17 DEAN HUSTON: We would be prepared  
18 to try, but we don't know how much the provincial  
19 governments in the future would be prepared to provide  
20 and how much they would have the Federal Government  
21 maintain its contribution. But we would be prepared to  
do the best we can.

22 COMMISSIONER FIRESTONE: Thank you.  
23 The best would be good enough, sir.

24 What we are looking for is your own  
25 advice and recommendations, that in putting some  
26 suggestions forward to the Canadian Government you would  
say this is the best advice we can give.

27 DEAN HUSTON: Yes, sir.

28 THE ACTING CHAIRMAN: I think it would  
29 be much more modest if you considered the total require-  
30 ments of the universities.



estimate that it is available in any one university,  
from provincial funds, from research grants, institutions  
and so forth. But I could certainly provide you with  
in detail about with possibly some accounts as to  
the various sources of funds. We would be prepared to  
do this, sir.

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that you would end up by making a suggestion of the  
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next ten years. Would that be possible?

LEAH HUSTON: We would be prepared  
to say, but we don't know how much the provincial  
governments in the future would be prepared to provide  
and how much they would have the Federal Government  
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do the best we can.

COMMISSIONER: Thank you.  
The best would be good enough, sir.  
That we are looking for is our own  
advice and recommendations, that in future some  
suggestions forward to the Canadian Government you would  
say this is the best advice we can give.  
LEAH HUSTON: Yes, sir.

THE ACTING CHAIRMAN: I think it would  
be much more useful if you considered the total number  
of the universities.



Huston

11401

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4 COMMISSIONER FIRESTONE: And it would  
5 be more in line with the terms of reference of this  
6 Commission.

7 I have one other question, Dr. Huston,  
8 with respect to paragraph 28 on page S.6 of your  
9 submission. You say:

10 "The Conference recommends that the  
11 "Royal Commission on Health Services  
12 "approved the concept of accreditation  
13 "of pharmacies, to be based upon  
14 "a specified standard of practice."

15 Could you offer some advice as to  
16 what you mean by "specified standard of practice"?

17 DEAN HUSTON: Yes. What we have in  
18 mind, sir, is establishment of standards of practice  
19 under which the various pharmacies in the several  
20 provinces might operate. This could be worked out in  
21 detail, as I comment in the brief. The Canadian  
22 Pharmaceutical Association Committee is working on this,  
23 it is being investigated in a number of provinces, and  
24 some concepts of such standards of practice have been  
25 worked out, and in this regard the University of Toronto  
26 has made certain studies here. I think Dean Hughes  
27 could make some comments which would be of utility here.

28 DEAN HUGHES: The studies are made  
29 under the College of Pharmacy, and in 1960 a certain  
30 committee on minimum standards did recommend to Council  
a basis for us. If I may go over the headings.

First, they dealt with the premises,  
then the area of the prescription department, fixtures  
and facilities within the prescription department,





CONFIDENTIAL - EYES ONLY

be made in line with the terms of reference of this

I have one other question, Minister,

with respect to paragraph 28 on page 16 of your

submission. You say:

"The Conference recommends that the

"Royal Commission on Health Services

"approved the concept of accreditation

"of pharmacies, to be based upon

"a specified standard of practice."

Could you offer some advice as to

what you mean by "specified standard of practice"?

MR. HARRIS: Yes, what we have in

mind, sir, is establishment of standards of practice

under which the various pharmacies in the country

pharmacies might operate. This could be worked out in

detail, as I comment in the report. The Canadian

Pharmaceutical Association Committee is working on this,

it is being investigated in a number of provinces, and

some concepts of such standards of practice have been

worked out, and in this regard the University of Toronto

has made certain studies here. I think I can say

could make some comments which would be of value here.

MR. HARRIS: The studies are made

under the College of Pharmacy, and in 1963 a certain

committee on minimum standards of practice was set up to Council

a model for it. If I may go over the highlights,

first, they dealt with the practice,

then the area of the prescription requirement, then the

and facilities within the prescription department,



Huston

11402

compounding and dispensing equipment, additional equipment and minimum library. Those were the headings. I have the details here, too, sir.

COMMISSIONER FIRESTONE: Would you visualize such standards as have been developed in one particular province or are under consideration in a particular province be adopted uniformly across the country?

DEAN HUGHES: I think that probably a better plan would be for the Canadian Association, which is a federation of all the statutory bodies, to attempt to unify the opinions of the different provinces.

THE ACTING CHAIRMAN: It would be the accrediting body, would it?

DEAN HUGHES: It is a good suggestion, sir.

THE ACTING CHAIRMAN: If not, what do you have in mind?

DEAN HUGHES: Basically we would have to admit a legal basis that it is a provincial responsibility. The Pharmaceutical Acts of the various provinces concern only the pharmacy within that province.

THE ACTING CHAIRMAN: I am a little confused as to what you mean by accreditation. In the hospital field there are hospitals which are accredited and there are hospitals which are not. Are you merely going to give a certificate to the pharmacist who lives up to the minimum standards or are you going to say that the pharmacist who doesn't live up to these standards



consuming and dispersing equipment, facilities,  
equipment and library. Those were the houses.  
I have the best of you, too, sir.

ON VICTOR'S QUESTION: Would you

be willing such standards as have been developed in one  
particular province or are under consideration in a  
particular province be adopted uniformly across the

MR. HUNTER: I think it is probably

a better plan would be for the Canadian Association,

which is a representative of the statutory bodies, to bring

together the opinions of the three provinces.

THE VICE-CHAIRMAN: It would be the

representing body, would it?

MR. HUNTER: It is a good suggestion.

Mr.

THE VICE-CHAIRMAN: Is not that

to be done in this

MR. HUNTER: Basically, we would have

to have a central body that it is a provincial

association, the Pharmaceutical Association of the provinces

provinces would only the primary with that

"I think we should have a little

committee to what you may call a committee. In this

committee there are people who are interested

and there are people who are not, but we really

need to give a certificate to the pharmacist who lives

in the province and on the other hand, say that

the pharmacist who doesn't live in the province





Hughes

11403

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4 can't practise. They are two different things.

5 DEAN HUGHES: May I say that the  
6 recommendation within the framework of the brief deals  
7 only with the pharmaceutical service provided under  
8 a national health plan, page S.6 number 28.

9 THE ACTING CHAIRMAN: That, of course,  
10 gets the Commission in even more difficulty.

11 COMMISSIONER FIRESTONE: I am just  
12 trying to visualize how one can put your idea into  
13 practice. This is what we are after, some guidance.  
14 There seems to be a great deal of merit in the suggestion,  
15 but how do you translate a suggesting into practice?

16 DEAN HUGHES: I would express the  
17 personal view only, Mr. Firestone, that basically this  
18 would remain a provincial -- under the Pharmacy Act  
19 of each province that one would hope the Canadian  
20 Pharmaceutical Association would be able to bring together  
21 the opinions of all the different statutory bodies so  
22 they would be uniform.

23 THE ACTING CHAIRMAN: So that they  
24 would lay down physical requirements; these are physical  
25 requirements?

26 DEAN HUGHES: Yes.

27 THE ACTING CHAIRMAN: Which the  
28 pharmacist must comply with in order to get his certifi-  
29 cate renewed.

30 DEAN HUGHES: In order to maintain what  
would be called a shop licence under the Pharmacy Act  
of the Province.



can't practice. They are two different things.

MR. HARRIS: Now I say that the

recommendation within the framework of the chief clerk

only with the pharmaceutical service provided under

a national health plan, para 2.6 number 2.

THE ACTING CHAIRMAN: That, of course,

means the Commission in even more difficulty.

MR. HARRIS: I am just

trying to visualize how one can put work into

practice. This is what we are after, some evidence

there seems to be a great deal of spirit in the suggestion

and how do you translate a suggestion into practice?

MR. HARRIS: I would express the

personal view only, Mr. Harrington, that basically this

would remain a provincial matter. The Health Act

of each province that one would have the Canadian

Pharmaceutical Association would be able to bring together

the members of all the different provincial bodies so

that would be uniform.

THE ACTING CHAIRMAN: So that they

would lay down physical requirements; these are physical

requirements.

MR. HARRIS: Yes.

THE ACTING CHAIRMAN: Will it be

pharmaceutical must comply with it, even to get his certificate

renewed.

MR. HARRIS: In order to maintain work

would be called a shop. How do you see the way to

of the province.



Huston

11404

lcH/dpw

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4 COMMISSIONER FIRESTONE: This, I think,  
5 I quite can see and quite well understand. I am just  
6 wondering, what would you expect the Federal Government  
7 to do in this situation and as I understood you earlier  
8 you made some reference to the operation of this sort  
9 of proposal in the medical care plan. Was it in that  
10 connection or a comprehensive health care plan; was it  
11 in that connection that you had anticipated the Federal  
12 Government to make some contribution towards this  
13 objective or did I not understand you on this point?

14 DEAN HUSTON: I think the point we  
15 are making here is not suggesting that you suggest to  
16 the Government that they establish an accreditation  
17 system; we are suggesting to the Royal Commission that  
18 you approve the concept of the provincial bodies  
19 establishing a system of accreditation.

20 THE ACTING CHAIRMAN: You are using  
21 us - I do not complain about this at all because you  
22 are not the first people to do it but you are using us  
23 for a sounding board for something in your own profes-  
24 sional hands.

25 DEAN HUSTON: A little more than that.  
26 I think the Commission recognizes a very moral puissance  
27 and if you say something is good it will carry weight  
28 later.

29 THE ACTING CHAIRMAN: You certainly  
30 kissed the Blarney Stone.

COMMISSIONER FIRESTONE: You are  
suggesting we should offer a certain amount of encourage-  
ment to what you consider is a desirable practice?





11-10-1964

THE ACTING CHAIRMAN: Now, I think,

I quite can see that you are all in agreement. I am just  
wanting, what would you expect the Federal Government  
to do in this situation and as I understand you are all  
you have some proposals to the effect of this cost  
of proposal in the medical care plan. Was it in that  
connection or a comprehensive health care plan; was it  
in that connection that you had anticipated the Federal

Government to make some contribution towards this  
initiative or did I not understand you at this point?  
MR. HUSTON: I think the point was

an asking here is not suggesting that you suggest to  
the Government that they establish an organization  
system; we are suggesting to the Royal Commission that  
you approve the concept of the provincial hospital

THE ACTING CHAIRMAN: You are saying

that I do not understand about this at all but that you  
are not the first people to do it but you are asking  
for a standing board for something in your own province  
local board.

MR. HUSTON: A little more than that.

I think the Commission recognized a very novel suggestion  
and it is very something in good it will carry weight

THE ACTING CHAIRMAN: You are saying

MR. HUSTON: I think that is all

suggesting we should offer a certain amount of money  
to what you consider in a desirable way.



Huston

11405

DEAN HUSTON: Yes, sir.

THE ACTING CHAIRMAN: Dr. Huston, on the previous page, S5, you say:

"...the Conference recommends that would be endorsed by the Royal Commission on Health

Services endorse the establishment of a Pharmacy Examining Board of Canada."

Now, that recommendation, as I read it, is substantially for the same end as the recommendation we have just been discussing?

DEAN HUSTON: That is right.

THE ACTING CHAIRMAN: Because that again is a matter completely in the hands of the present licensing bodies.

DEAN HUSTON: Yes sir, we would like your support for that concept.

THE ACTING CHAIRMAN: Why do you recommend that pharmaceutical firms use only pharmacists - you do not go that far, you say "or other scientifically well-trained personnel as medical service representatives." What would you include in "other scientifically qualified persons"?

DEAN HUSTON: Other people with similar high quality backgrounds. I think that a pharmacist would have the best possible background with his background in chemistry, physical and biological sciences, pharmacology. In this concept pharmaceutical firms might use a medical doctor as such a representative and we have broadened it to include others that are highly



THE ACADEMY OF NATURAL SCIENCES

the Royal Commission on the

of a "National Academy of

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Now, that is a recommendation, as I recall it,

is substantially for the same end as the recommendation

to have just been discussed.

OF AN ACADEMY: That is right

THE ACADEMY OF NATURAL SCIENCES

It is a matter of course in the hands of the present

ALAN HUSTON: Yes sir, we would like

Your support for that concept.

THE ACADEMY CHAIRMAN: Why do you

recommend that organizational forms are only parasitic

you do not go that far, you say "or other scientific

well-known, essential as natural science is to human progress.

What would you include in "other scientifically justified"

ALAN HUSTON: These people with similar

rightfully professional. I think that a government

would have the best of both worlds. It is the best

to be in chemistry, physics and the natural sciences,

biology. In this case, I think that a

might use a word or two as well as a few sentences

to be included in the list of things that are





Huston

11406

qualified or other persons with degrees in science.

THE ACTING CHAIRMAN: Chemistry?

DEAN HUSTON: Chemistry; that would give them a sufficiently strong background that they would be speaking with knowledge and effectiveness.

THE ACTING CHAIRMAN: I do not wish to argue the point here because we have heard many submissions on both sides and I just want to get your opinion.

I take it from this recommendation that you believe that the medical detailman, call him that, hired by the pharmaceutical manufacturer or distributor, serves a useful purpose, performing a necessary function that is useful to the members of the community and the medical profession in particular?

DEAN HUSTON: Yes, sir, that is so, when well-qualified. I have stated that in the brief that when well-qualified he serves a useful purpose. If he is not well-qualified he becomes a salesman and does not make a useful contribution educationally to those who are in contact with him.

THE ACTING CHAIRMAN: He may make a sales contribution?

DEAN HUSTON: That is right but we are interested in the educational aspects of a pharmaceutical representative and we feel a person like that in calling on doctors and pharmacists could perform a useful function.

COMMISSIONER BALTZAN: Is the detailman helpful to the pharmacist? Does he provide them with an



...or other persons who are in a position

THE ACTING CHAIRMAN: The answer

DEAN HUSTON: That would

give you a satisfactory answer regarding that they

would be speaking with knowledge and efficiency.

THE ACTING CHAIRMAN: I do not wish

to argue the point here because we have heard many

suggestions on both sides and I just want to get your

I take it from this recommendation

that you believe that the medical profession, as a whole,

that, hired by the Government, can be of service to the

factor, serves a useful purpose, performing a necessary

function that is useful to the members of the community

and the medical profession is particularly

when well-qualified. I have stated that in the field

that when well-qualified he serves a useful purpose.

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those who are in contact with him.

THE ACTING CHAIRMAN: We may take a

series of questions.

DEAN HUSTON: That is right, but we are

interested in the educational aspects of a pharmaceutical

representative and we feel a certain lack of interest

on doctors and other medical people to perform a useful

function.

THE ACTING CHAIRMAN: We will take a

series of questions. I will ask you to answer them with an



Huston

11407

extra education? Is he important to the pharmacist?

DEAN HUSTON: I would say, yes, when he is well-qualified. If he is a well-qualified detailman he can be a very useful educational tool to the practising pharmacist just as he could be for a practising physician.

COMMISSIONER BALTZAN: Let me put it another way: could pharmacists do without the detailman and still keep up to date?

DEAN HUSTON: It would be much more difficult because he would then have to rely upon his reading and extension courses and the other things that are open to him to keep up to date. As I am sure you are aware, it is very difficult to keep up to date with pharmaceutical advertising; they are so rapid, so that every avenue that is of utility in keeping up to date should be used and the detailman is one such avenue.

DEAN MATTHEWS: I think we have to view this matter we are discussing along with another matter in which certain recommendations have been made and that is the recommendation that has been made about continuing education and the need for expanding of the continuing education program for pharmacists in practice.

Now, you would probably agree that the same thing is necessary in medicine and is being done to a greater degree in medicine now than formerly. I would say as continuing education programs expand perhaps a very good purpose will be served by taking another close look at this whole matter of the type of promotion that is done by the industry.



extra educational is so important to the pharmacist

DR. HUSTON: I would say, yes, when

he is well-versed in the well-qualified details

and he can be a very useful educational tool to the

pharmacist, pharmacist, but as he could be for a pharmacist

being pharmacist.

DR. HUSTON: Let me put it

another way: could pharmacists comment the details

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say as continuing education programs expand perhaps a

very good deal will be served by taking another closer

look at this whole matter of the type of promotion that

is done in the industry.



Matthews

11408

It may well be that over a few years could be developed continuing education such as is being done now in medicine at the University of British Columbia which is going on under a Foundation.

COMMISSIONER BALTZAN: That is very good and is a procedure that has been going on for quite some time for people who are interested in keeping up to date.

DEAN MATTHEWS: My point is there has existed something of a vacuum in both fields between the accreditation of a practitioner and the time he is now practising which has not been possible for him to entirely keep himself informed. These continuing education programs will help greatly in this respect and perhaps lessen the need for these extraneous aids he has been using.

COMMISSIONER BALTZAN: I am interested in what I have just heard and that is that you feel the detailman performs an educational function beyond what some people might conceive as a promotional function?

DEAN MATTHEWS: In my own mind I am quite clear on this and I would repeat what Dr. Huston said; that if he is well-qualified he can do this.

--- Chief Justice Emmett M. Hall takes the Chair from Mr. M. Wallace McCutcheon, Q.C.

COMMISSIONER McCUTCHEON: Well, if I can turn to one other point; you make the statement:

"...the present grouping by federal



it will be that over a few years could be  
developed something of a tradition such as is now  
in vogue at the University of British Columbia  
which is going on under a Foundation.

There is a procedure that has been going on for  
quite some time for people who are interested in keeping  
in touch.

THOMAS MATTHEWS: My point is there is a

exists something of a vacuum in both fields between  
the association of a practitioner and the time he is  
now practicing which has not been possible for him to  
entirely keep himself informed. These continuing  
education programs will help greatly in this respect  
and perhaps lessen the need for these extensive efforts  
he has been using.

CHARLES WATKINS: I am interested

in what I have just heard that is that you feel that  
there is a vacuum in educational function beyond what  
exists now a right to have as a professional function?  
THOMAS MATTHEWS: In my own mind I am  
quite sure on this and I would repeat what I have  
said, that if we are well-served by this

--- On the other hand, Mr. Hall, I am the other hand

On the other hand, Mr. Hall, I am the other hand

On the other hand, Mr. Hall, I am the other hand

"...the other hand, Mr. Hall, I am the other hand"





Huston

11409

administration of food and drugs  
together is unwieldy, inefficient  
and unsatisfactory."

The Association makes an identical  
recommendation in regard to that. Would you like to  
expand on that? What is your basis for "unwieldy,  
inefficient and unsatisfactory"?

DEAN HUSTON: Well, we feel that the  
supervision of pharmaceutical matters, drugs, are  
better handled by people trained at all levels in  
pharmacy and in drugs. It seems inappropriate and  
inefficient to use the food technologists to investigate  
drug plans. We feel that pharmacists can be much more  
effective in dealing with pharmaceutical matters.

These are two such big areas of govern-  
mental undertaking that it is unwieldy to group them  
together and they would be more efficient as separate  
and distinct entities.

COMMISSIONER McCUTCHEON: Are you  
suggesting that they have not got trained people now,  
qualified people?

DEAN HUSTON: I know that some of the  
inspectors, for instance, in many provinces are not  
pharmaceutically-oriented people. I have had them  
occasionally come over and speak to students on matters  
pertaining to pharmacy and they are obviously completely  
at sea. That is in one specific example I know of.  
Perhaps my colleagues would like to comment further.

DEAN HUGHES: I would agree with what  
Dr. Huston said.



1100

Huston

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together is unwise, inefficient  
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The Association makes an identical  
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effective in dealing with pharmaceutical matters.

There are two such big areas of govern-

mental undertaking that it is unwise to group them  
together and they would be more efficient as separate  
and distinct entities.

CONSTITUTIONAL MODIFICATION: Are you

suggesting that they have not got trained people nor  
qualified people?

BLAN HUSTON: I know that some of the

instructors, for instance, in many provinces are not  
the academically-oriented people. I have had them  
occasionally come over and speak to students on matters  
pertaining to pharmacy and they are obviously completely  
at sea. That is in one specific example I know of.  
Perhaps my colleagues would like to comment further.

BLAN HUSTON: I would agree with what

Dr. H. also said.



Matthews

11410

DEAN MATTHEWS: I would point out, going back to the root of this, I think history shows that when the Food and Drug Division of the Department of National Health and Welfare was first set up its principal interest was mainly in the direction of protecting the public against fraud and misrepresentation.

To a very large degree this still continues to be the primary interest in relation to food but certainly in relation to drugs the picture has changed very greatly and while it is a very important consideration yet in regard to drugs it is a matter of standards and details pertaining to the highly specific nature of drugs that are covered now in the food and drug regulations which have increased tremendously in recent years and the approach, in other words, to enforcement in relation to drugs.

If we exclude that one area of misrepresentation it is quite a different matter altogether. Now, we feel it requires a different approach and a different type of training. We do not see that it has been brought to the degree we would like to see it at the present time. The whole area of narcotic inspection, of course, has been divorced to a fairly large extent from the ordinary administration of the Food and Drug Directorate; they are more or less separate items now.

Therefore, the actual work on that in practice, as far as pharmacy is concerned, has been very much better so far as narcotics are concerned as compared with the ordinary drug inspection.

COMMISSIONER McCUTCHEON: Thank you





1944-1945. I would point out,

going back to the rest of this, I think history shows that when the Food and Drug Division of the Department of National Health and Welfare was first set up its

original interest was mainly in the direction of protecting the public against fraud and misrepresentation. To a very large degree this still

continues to be the primary interest in relation to food but certainly in relation to drugs the picture has changed very greatly and while it is a very important consideration yet in regard to drugs it is a matter of standards and details pertaining to the highly

scientific nature of drugs that are covered now in the food and drug regulations which have increased tremendously in recent years and the approach, in other words, to enforcement in relation to drugs.

It is evident that one area of enforcement is quite a different matter altogether. Now, we feel it requires a different approach and a different type of training. We do not see that it has been proper to the degree we would like to see it at

the present time. The whole area of narcotic legislation, of course, has been divided to a fairly large extent from the ordinary administration of the Food and Drug Administration; they are now on two separate planes now. Therefore, the actual work on that in

relation, as far as enforcement is concerned, has been very much better as far as narcotics are concerned as compared with the ordinary food legislation.

Thank you very much.



11411

very much.

THE CHAIRMAN: I missed part of the questioning and, therefore, what I am saying might be redundant and unnecessary. However, there are two topics that may be relative in this context that we hear from all sides there is a shortage of druggists, of graduate druggists and that there ought to be expanded facilities in various parts.

It is suggested here and there that we should have some more colleges. I know that you were discussing this point with Dr. Baltzan a moment ago but should it be the function of the College of Pharmacy, of the Colleges of Pharmacy, to train specialized salesmen for the drug industry?



very much.

THE CHAIRMAN: I missed part of the  
discussion and, therefore, what I am saying might be  
redundant and unnecessary. However, there are two  
points that may be relevant in this context that we  
hear from all sides there is a shortage of specialists,  
of graduate engineers and that there ought to be  
expanded facilities in various parts.  
It is suggested here and there that  
we should have some more colleges. I know that you  
were discussing this point with Dr. Bhatia a moment  
ago but should it be the function of the College of  
Engineering, of the College of Pharmacy, to train  
specialized personnel for the drug industry?





/PB/hm

11412

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3 You have a recommendation which says  
4 apparently you subscribe to that view. I just wonder how  
5 soundly based you may wish to say that view is.

6 DEAN HUSTON: This was covered to  
7 some extent before your entrance and it was based upon  
8 the concept that the well trained detailman can be a  
9 very useful person in an educational way to both the  
10 pharmacist and the practising physician. If he is not  
11 well trained he becomes merely a sales promoter.

12 THE CHAIRMAN: Dr. Huston, my concern  
13 is ought it be the function of the College of Pharmacy,  
14 the universities to train such people to inform the  
15 doctors? Shouldn't they be informed in their own medical  
16 schools, know their own business before they go out  
to practise medicine?

17 DEAN HUSTON: This is a matter of  
18 assisting them and keeping up to date on new developments.  
19 That is where the detailman makes his principal contri-  
20 bution. It seems to us that the function of the detail-  
21 man is a proper aspect of the overall pharmaceutical  
22 profession and therefore he should be professionally  
23 trained and the place to get such training is in the  
Pharmacy College. We therefore submit it is appropriate.

24 THE CHAIRMAN: How many pharmacists  
25 do you graduate a year in Canada, by and large?

26 DEAN HUSTON: I think we have that  
in a table.

27 THE CHAIRMAN: In round figures?

28 DEAN HUSTON: Around 290, 300, sir.

29 THE CHAIRMAN: We were told by the  
30





Huston

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4 Pharmaceutical Manufacturers' Association that they  
5 employ about 1,200 detailmen in Canada, that is about  
6 one for every twelve doctors in practice in Canada,  
7 almost four years output of the entire Pharmacy Colleges  
8 in this one operation.

9 DEAN HUSTON: They are not all  
10 pharmacists now, at the present time, sir, of course.

11 THE CHAIRMAN: If your view prevails  
12 they all will be?

13 DEAN HUSTON: Yes sir. If they have  
14 very effective people they may be would not need as  
15 many.

16 THE CHAIRMAN: That is your view. The  
17 other aspect of the matter of personnel, shortage of  
18 personnel may arise in this way: We have been told  
19 here and there that the average pharmacist only devotes  
20 so many hours a day as a pharmacist and a considerable  
21 portion of the hours of his time as a vendor of other  
22 articles, whether they are over the counter drugs or  
23 whatever you want to call them. It is stressed that  
24 is necessary particularly in the rural areas.

25 DEAN HUSTON: Yes sir.

26 THE CHAIRMAN: I would be prepared to  
27 accept that, but in the urban areas is there any prospect  
28 that in these urban areas the pharmacists may be either  
29 elevated or restored to their position as professional  
30 persons and not as vendors of merchandise.

DEAN HUSTON: Well, I don't like the  
term being restored to their professional position  
because they have a professional position which they are







Huston

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3 now filling competently.

4 THE CHAIRMAN: I should say restore  
5 to full professional position.

6 DEAN HUSTON: That helps a little.  
7 This was dealt with indirectly, sir, before you came  
8 in in the concept of accreditation of pharmacies. It  
9 has been suggested by us that pharmacies might be  
10 accredited by the standard of practice which would be  
11 established by the various provincial pharmaceutical  
12 associations in co-operation with the Canadian Association,  
13 and in establishing such terms of accreditation it  
14 might well be that the terms would make greater use of  
15 the pharmacists' time.

16 THE CHAIRMAN: These matters must  
17 necessarily be related to the complaint that we are not  
18 graduating enough pharmacists?

19 DEAN HUSTON: Yes sir. We would  
20 anticipate there would be, as I mentioned in the brief,  
21 not a great development in the number of pharmacies  
22 in the future, that there would be relocation of pharmacies  
23 and each pharmacy would serve a larger number of people.

24 COMMISSIONER McCUTCHEON: It is very  
25 difficult to find the prescription department in some  
26 pharmacies.

27 DEAN HUSTON: That is right, sir. This  
28 sort of thing, I might add would be taken into account  
29 in the terms of accrediting the pharmacies.

30 THE CHAIRMAN: I don't quite follow  
what you mean by accrediting the pharmacy.

DEAN HUSTON: We had a bit of a go on



now talking cooperatively.

Dr. HUBBARD: I should like to mention

to tell professional position.

It is was dealt with indirectly, sir, before you came

in in the concept of a classification of personnel. It

has been suggested by us that practices might be

accounted by the standards of practice which would be

established by the various professional organizations

associations in co-operation with the Canadian Association

and in establishing such terms of association in

what will be that the terms would make greater use of

the professional terms.

THE CHAIRMAN: I see not any great

necessity to relate to the committee that we are not

DR. HUBBARD: Yes sir, a word.

Anticipate there would be, as I mentioned in the past,

not a great development in the number of characters

in the future, that there would be reduction of personnel

and each character would have a larger number of people

DR. HUBBARD: Yes sir, it is very

difficult to find the professional relationship in some

DR. HUBBARD: I think it is very important, sir. This

sort of thing, I think it would be very important

in the terms of accounting in the professional

DR. HUBBARD: I don't think it is

what you really are accounting for the situation

DR. HUBBARD: I think it is very important, sir. This





Huston

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1  
2  
3 this earlier.

4 THE CHAIRMAN: This will be re-  
5 educational, continuing.

6 DEAN HUSTON: It was enquired of us  
7 what did we have in mind.

8 THE CHAIRMAN: Something like the  
9 detailman and the doctor.

10 DEAN HUSTON: What we had in mind  
11 that your Commission might do in their contact with the  
12 Federal Government with regard to such a matter. I  
13 pointed out we were seeking their moral support for the  
14 concept of accreditation. This would strengthen and  
15 fortify the approach of the professional bodies in  
16 developing such terms of accreditation and getting  
acceptance of them.

17 THE CHAIRMAN: I am afraid I don't  
18 follow you for the moment. That will be my fault.  
19 Accreditation would involve what? I mean to say a  
graduate pharmacist in a location prepares to .....

20 DEAN HUSTON: It is accreditation of  
21 the pharmacy, the terms under which the pharmacy might  
22 operate, and Dean Hughes had read out some suggestions  
23 that had been developed by the Ontario College. Would  
24 you like to hear those?

25 COMMISSIONER McCUTCHEON: It was with  
26 respect to physical facilities.

27 DEAN HUSTON: Would you like to hear  
28 these?

29 THE CHAIRMAN: No, it is all right.

30 DEAN HUSTON: It might well be, sir,



Mr. Chairman: This will be the

Chairman: It was enclosed of the

What this has been in mind.

THE CHAIRMAN: Something like the

relation and the doctor.

THE CHAIRMAN: What we had in mind

that your commission might do in their contact with the

Federal Government with regard to such a matter. I

advised out we were seeking their moral support for the

concept of accreditation. This would strengthen and

justify the approach of the professional bodies in

developing such terms of accreditation and setting

any standards of them.

THE CHAIRMAN: I am afraid I don't

follow you for the moment. That will be my fault.

Accreditation would involve what? I mean to say a

graduate pharmacist is a location process to....

THE CHAIRMAN: It is accreditation of

the pharmacy, the terms under which the pharmacy would

operate, and then further and out some standards

that had been developed by the Ontario College. Would

you like to hear that?

THE CHAIRMAN: Yes, I would like to hear

about the pharmacy and about that.

THE CHAIRMAN: Well, you like to hear

the pharmacy and about that.

THE CHAIRMAN: It might well be, yes.



Huston

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4 that the people in the profession might have some  
5 contribution to make in the areas we are presently  
6 discussing. I am giving the academic point of view.  
7 It might be helpful to hear from Mr. Turnbull.

8 THE CHAIRMAN: That was the idea of  
9 having a joint discussion so they would be able to make  
10 any additional comments on the subject as they came up.

11 COMMISSIONER McCUTCHEON: I invited  
12 anybody to make comments from time to time.

13 THE CHAIRMAN: We are not being  
14 critical, Dr. Huston. We are just trying to fit this  
15 into a realistic picture.

16 DEAN HUSTON: Yes sir.

17 THE CHAIRMAN: If it is possible.

18 DR. MATTHEWS: Might I remind you of  
19 the figures presented in the brief of the British  
20 Columbia Pharmaceutical Association that showed the  
21 number of pharmacists per store on the average increased  
22 from the figure of 1.8 per store in 1930 to 2.3, or  
23 something of that sort. I believe the figure was at  
24 1940, 1950 and 1960. I am just quoting from memory,  
25 but it is increasing which would indicate there is  
26 tending to be a greater concentration of pharmacists  
27 in a smaller number of stores with the effect that,  
28 naturally, the utilization of service will be more  
29 efficient.

30 THE CHAIRMAN: I recall this in British  
Columbia now that you mention it. Are there any more  
questions?

COMMISSIONER VAN WART: On page 177 of





that the way in this profession might have been  
 contribution to make in the areas we are presently  
 discussing. I am giving the academic point of view.  
 It might be helpful to hear from Mr. Thompson.

THE CHAIRMAN: That was the idea of

having a joint discussion so they would like to make  
 any addition I comments on the subject as they came up  
 COMMISSIONER HARRISON: I wanted

now say to make comments from time to time

THE CHAIRMAN: We are not going

national, Dr. Huxton. We are just trying to fit this  
 into a realistic picture.

THE CHAIRMAN: Yes and

THE CHAIRMAN: It is possible.

DR. HARRISON: What I mean you of

the index presented in the end of the British

Statistical Publications, in relation that showed the

number of diamonds per acre on the average increased

from the figure of 1.5 per acre in 1955 to 2.3 in

some kind of sort. I believe the figure was at

1940, 1950 and 1960. I am just getting from memory.

but it is important which would indicate there is

nothing to be done as a consequence of this

in a very small number of cases with the effect that

in turn, the production of diamonds will be more

THE CHAIRMAN: I mean, this is British

diamonds now that is a question of the time and space

question

COMMISSIONER HARRISON: On page 17 of



Huston

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3 the large volume, the first paragraph, 13. 15. 6, you  
4 speak there of a commission being set up for overall  
5 supervision. Do I infer by that that you don't want  
6 any plan to be regulated through the departments of  
7 health but through a commission outside the departments?

8 MR. TURNBULL: Our submission here,  
9 Dr. Van Wart, refers to the administration not only  
10 activation, but also policy administration of any  
11 program which might bring into effect some plan of  
12 health care for Canadian citizens. Our reference here  
13 is to the great need to have pharmacists as an integral  
14 part of the Commission at the policy-making level, at  
15 the administration level as well as at the practising  
16 level so that the top level control and guidance relevant  
17 to pharmaceutical matters in the practice of the profession  
18 as well as drug matters may be viewed by someone who  
19 has professional training and is an expert in such  
20 matters.

21 COMMISSIONER VAN WART: My question  
22 was whether or not you visualized the Commission made  
23 up of groups including pharmacists to look after the  
24 overall policy and overall administration or do you see  
25 this in the departments of health?

26 MR. TURNBULL: This, I believe, in  
27 referring to our first sentence "Appointed by the  
28 sponsoring government or other insuring agency -- our  
29 reference to the commission, it is merely a matter of  
30 terminology. Reference was to various hospital service  
commissions which do exist in many provinces of Canada.  
The term commission is presently used. I believe I







Huston

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3 must answer your question yes. It is to be expected  
4 that a program of health care for Canadians would pre-  
5 sumably be overseen by a Commission, not necessarily  
6 directly related to the particular government departments  
7 of public health or health or national health.

8 COMMISSIONER VAN WART: One other  
9 question that came up from a submission we had yesterday  
10 in which they stated that the pharmacists were doing  
11 laboratory examinations and we asked why and they said  
12 the pharmacists consider themselves as chemists. Is that  
13 true or not true?

14 MR. TURNBULL: I am not familiar with  
15 the brief that was presented or who may have presented  
16 it. Some pharmacists through their academic training  
17 do take specialized training in laboratory techniques,  
18 not all do. It is elective on many of the faculties. I  
19 don't know that you would find this is a very prevalent  
20 practice.

21 COMMISSIONER VAN WART: Do you have  
22 any comment on that?

23 DEAN HUSTON: I would comment there that  
24 the background that pharmacy graduates have would enable  
25 them with little difficulty the mastering of such  
26 techniques. All the pharmacy colleges teach biochemistry  
27 and bio-chemical techniques which give them training  
28 background that would enable them to do tests such as  
29 I think you have in mind. They have extensive training  
30 in modern instrumental methods of analysis and this type  
of thing in the pharmacy courses which would lend itself  
very well to a variety of tests.

that answer your question was. It is to be expected  
that a system of health care for Canadians would pro-  
bably be overseen by a Commission, not necessarily  
directly related to the particular government departments  
of a local health or health or national health.

COMMISSIONER VAN WAT: One other

question that came up from a submission we had yesterday  
in which they stated that the pharmacists were doing  
laboratory examinations and we asked why and they said  
the pharmacists consider themselves as chemists. Is that  
true or not?

MR. TUNNEY: I am not familiar with  
the fact that was presented or who may have presented  
it. Some pharmacists through their academic training  
do take specialized training in laboratory techniques,  
not all do. It is elective on many of the faculties. I  
don't know that you would find this is a very prevalent

COMMISSIONER VAN WAT: Do you have

any comment on that?

MR. TUNNEY: I would answer those that

the background that pharmacy graduates have would enable  
them with little difficulty to master the use of  
equipment. All the necessary college work in chemistry  
and biological techniques which give them training  
enabling them to be able to do tests such as  
which you have in mind. They have extensive training  
in chemical analytical methods or analytical and this type  
of work in the pharmacy course which would enable them  
very well to a variety of tests.



Turnbull

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THE CHAIRMAN: The reference in your recommendation 13, the last couple of lines:

"That pharmacists be employed in the  
"control laboratories and that individuals  
"with a baccalaureate degree in pharmacy  
"be eligible for positions as analytical  
"chemists".

DEAN HUSTON: This is relevant to the Food and Drug Directorate but it is pertinent to what we are discussing here, the pharmacists have the background.

THE CHAIRMAN: If they are going to have this background they would be eligible as analytical chemists as far as pregnancy tests are concerned, that is what we heard about yesterday.





THE CHAIRMAN: The reference in your

"that someone be employed in the

"control laboratories and that

"with a considerable degree in which

"be eligible for position as

THE CHAIRMAN: This is relevant to the

we are discussing here, the pharmacists have the

THE CHAIRMAN: If they are going to

have this background they would be eligible as analytical

chemists as far as pregnancy tests are concerned, that

is what we heard about yesterday.



Huston

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AG/dpw

DEAN HUSTON: That is right, sir.  
They would need some orientation in specific tests.  
If you are going to use pregnancy tests as an example,  
these are not done routinely ---

THE CHAIRMAN: That was the suggestion  
put forward yesterday afternoon, that this was being  
done in a rather general way in Toronto. They are  
holding themselves out as competent to make these body  
fluid tests.

DEAN HUSTON: Well, are you asking a  
question, sir? The point is ---

THE CHAIRMAN: Is a graduate pharmacist  
competent to do that?

DEAN HUSTON: Yes, sir, they are,  
certainly.

THE CHAIRMAN: So therefore there is  
nothing wrong in them doing it?

DEAN HUSTON: That is right, sir.

COMMISSIONER McCUTCHEON: The ugly  
head of competition rearing itself.

MR. TURNBULL: I didn't appreciate  
the context of the question. You will find this in a  
more generalized way, complete laboratory techniques  
required by the physicians practising within a building,  
but this, of course, is economically sound. There are,  
as well, all these various instruments and pieces of  
equipment that can be obtained, and the pharmacist is  
trained for this.

COMMISSIONER FIRESTONE: Mr. Chairman,  
if I may now address myself to Mr. Mitchell, Mr. Turnbull



And that is right, isn't it?

There would need to be some information in specific tests. If you are going to use probability, there is an exercise, these are not some random things.

not forward yesterday afternoon, that this was being done in a sort of normal way in Toronto. They are holding themselves out as competent to make these body

DAVID HUSTON: Well, are you saying a

...and, and the point is --

THE CHAIRMAN: Is a subject of discussion

competent to do that?

DAVID HUSTON: Yes, sir, they are.

THE CHAIRMAN: So therefore there is

nothing wrong in their doing it?

DAVID HUSTON: That is right, sir.

...of competition among itself.

...I want to go into

...of the ... and will find that in a

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Turnbull

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and Mr. Summers, to the brief which we have before us of the Canadian Pharmaceutical Association. May I turn first to paragraph S-9 on page IV of the summary.

In this paragraph you recommend, and I quote:

"That all manufacturers of drugs and drug preparations be licensed and that such licensing be a prerequisite to manufacturing and a necessity for year-to-year continuation of manufacture."

Who should do the licensing?

MR. TURNBULL: The agency which assesses the drug for Canada-wide, or for Canadian distribution, which, at the present time, is the Food and Drug Directorate of the Department of National Health and Welfare.

COMMISSIONER FIRESTONE: And you would recommend that the Federal Government, through this particular Department, do the licensing as suggested in paragraph S-9?

MR. TURNBULL: Yes, sir. This is not unusual. Such licensing now does occur relative to products marketed under The Patent or Proprietary Medicine Act.

COMMISSIONER FIRESTONE: But you wish to have it extended to all companies within the meaning of paragraph S-9?

MR. TURNBULL: And, of course, as far as biologicals and injectable preparations presently covered by The Food and Drug Act administered by the



and Mr. de Maza, to the brief which we have before us  
 of the Canadian Pharmaceutical Association. May I  
 then first to paragraph 2-7 on page IV of the summary.  
 In this paragraph, you recommend, and

I quote:

"That all new factories of drugs  
 and drug preparations be licensed  
 and that such licensing be a  
 prerequisite to manufacturing and  
 a necessity for year-to-year  
 certification of manufacture."  
 Who should do the licensing

Mr. Thompson: The agency which assesses  
 the drug, the Canadian distillation,  
 which, at the present time, is the Food and Drug Direc-  
 torate of the Department of National Health and Welfare.  
 CO-ORDINATION ELKSTONE: And you would

recommend that the Federal Government, through this  
 particular department, be the licensing as suggested  
 in paragraph 2-7.

Mr. Thompson: Yes, sir. This is not  
 unusual. Such licensing now for some years has been  
 conducted under the Patent and Copyright

Act.

CO-ORDINATION ELKSTONE: I am not  
 to have a committee to all countries within the meaning  
 of paragraph 2-7.

Mr. Thompson: And, of course, as far  
 as other acts and injunctive legislation, please  
 covered by the Act and Drug Act are concerned, the



Turnbull

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Food and Drug Directorate, this is merely an extension to what already exists.

COMMISSIONER FIRESTONE: And you say this licensing would be on the basis of a year-to-year re-issuance of that licence. Is that the sort of system you have in mind?

MR. TURNBULL: Yes, sir.

COMMISSIONER FIRESTONE: Under what circumstances would you visualize that such a licence would not be a re-issue?

MR. TURNBULL: I find it very difficult to enumerate circumstances, Professor Firestone. However, in the previous sentence I think it relates to this, that where, in the opinion of the Minister, unsatisfactory methods have been found to be in evidence in manufacturing and it is found necessary to place an inspector in them to supervise the quality control and the manufacturing processes within that institution, that company would be suspect when the time came to renew its licence.

This, of course, I think, would be one of the matters to be considered, and, of course, the staffing of such an institution would have to come up to certain qualifications.

One of the most important parts of the pharmaceutical manufacturing plant would be the sanitary conditions in existence in that particular plant and one of the most important aspects of licensing is to ensure that each and every manufacturer and manufacturing institution is identified to the people who are administering these Acts.





Food and Drug Directorate, this is mainly a...  
to what directly exists.

QUESTION: And you say  
this licensing would be on the basis of a year-to-year  
renewance of that license. Is that the sort of  
system you have in mind?

ANSWER: Yes, sir.

QUESTION: Under what  
circumstances would you visualize that such a license  
would not be a restriction?

ANSWER: I find it very difficult

to separate circumstances, Professor First. However,  
in the previous sentence I think it refers to this, that  
where, in the opinion of the Minister, unsatisfactory  
methods have been found to be in evidence in manufacturing  
and it is found necessary to place an inspector in there  
to supervise the quality control and the manufacturing  
process within that institution, that concern would  
be a case where the line came to represent its license.  
And, of course, I think, would be one  
of the matters to be considered, and of course, the  
setting of such an institution would have to come up  
to certain standards.

One of the most important parts of the  
statement is mentioning what would be the authority  
which is expected in that institution, and  
one of the most important aspects of licensing is to  
ensure that each and every manufacturer of pharmaceuticals  
is licensed as to the quality of the products which are admini-



Turnbull

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COMMISSIONER FIRESTONE: Thank you very much, Mr. Turnbull. May we now turn to paragraph S-18, on page VII of the summary. You say, and I quote:

"The number of wholly Canadian-owned drug companies is today decreasing."

The implication of this paragraph is that you would like to see this trend reversed. Am I right in that appreciation?

MR. TURNBULL: Oh, yes.

COMMISSIONER FIRESTONE: What do you suggest could be done to reverse this trend?

MR. TURNBULL: Regrettably we are not in a position to make any recommendations with regard to this. This statement is made as a statement of fact in the opinion of the Association, and it is somewhat disappointing to find that some wholly Canadian-owned companies, which have a good reputation in the pharmaceutical field, are no longer wholly Canadian-owned companies.

COMMISSIONER McCUTCHEON: That is not unique to the drug field.

MR. TURNBULL: No, regrettably not.

COMMISSIONER FIRESTONE: Were the problems financial, marketing problems, research problems? What were their problems? What happened in the drug industry?

MR. TURNBULL: We are not aware of the problems along that line. I think that there are people with more knowledge than ourselves. I presume



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COMMISSIONER: Thank you.

very much, Mr. Turnbull. May we now turn to paragraph 2-18, on page 11 of the summary. You say, and I

"The number of wholly owned companies is today decreasing." The location of this paragraph is

that you would like to see this trend reversed. Am I right in that association?

COMMISSIONER: What do you

propose could be done to reverse this trend?

MR. TURNBULL: Respectfully we are not

in a position to make any recommendations with regard to this. This statement is made as a statement of fact in the opinion of the Association, and it is somewhat disappointing to find that some wholly owned companies, which have a good reputation in the pharmaceutical field, are no longer wholly owned companies.

COMMISSIONER: That is not

unique to the field.

MR. TURNBULL: No, respectfully not.

COMMISSIONER: I am sorry, but the

What were their positions? What happened in the industry?

MR. TURNBULL: We are not aware of the

proposals along that line. I think that there are

people who have knowledge and ourselves. I propose





Turnbull

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that the financial aspects enter into it.

COMMISSIONER McCUTCHEON: Someone offered them an attractive price and they sold out.

COMMISSIONER FIRESTONE: In this same paragraph, S-18, you say that, and I quote:

"Canada must consider itself as being in an extremely poor strategic position relative to drug supplies in the event of any emergency situation, as drugs, unlike cameras, and other extensively imported consumer commodities, are vital to the nation's existence."

I take it that you would like to see more of Canada's drug requirements manufactured in Canada, whether these companies are foreign-controlled or Canadian-owned. Is that the point?

MR. TURNBULL: Most definitely, sir.

COMMISSIONER FIRESTONE: Well now, sir, we have heard that Canada has a smaller market than the markets of many other countries where drug manufacturers operate, and there might be the tendency of Canadian-based drug manufacture, whether foreign-controlled or Canadian-owned, to produce such drugs at higher cost.

You would feel that higher prices of drugs would be a price one should pay to manufacture more of those drugs in Canada?

MR. TURNBULL: I think the pharmacists of Canada would be the last to advocate any steps which might increase the price of drugs in Canada. However,



that the financial sector is in it.

100. It is also in it.

ordered that all appropriate measures be taken.

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Turnbull

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our suggestion here is that in view of the fact that the Canadian population is growing, that the ability and know-how is certainly within the grasp of Canadians, that it would be most desirable to have more and more of the actual manufacturing procedure done on Canadian soil.

COMMISSIONER FIRESTONE: Where this can be done economically, is that your point?

MR. TURNBULL: We hope that it can be done economically, yes.

THE CHAIRMAN: I believe you were here the other morning when Mr. Conder was being questioned?

MR. TURNBULL: Yes, sir.

THE CHAIRMAN: My recollection is that he said that this statement, which I put to him, was not factually correct, and that about 90% of the drugs used in Canada today were manufactured in Canada.

COMMISSIONER McCUTCHEON: The basic chemicals being imported in many cases.

MR. TURNBULL: Well, I think possibly the definition of manufacturing ---

THE CHAIRMAN: We had a discussion of that, as you remember.

MR. TURNBULL: --- is somewhat broad. May I draw your attention to our page 41, where we present a definition of manufacturing as including source production procedures involved with the extraction, synthesis, and the purification of the crude drug in bulk form, and including the fabrication of individual





the operation of the law is that in view of the fact that  
the law is not a mere statement of principle, but a  
statement of principle which is binding on the courts,  
and it is not a mere statement of principle, but a  
statement of principle which is binding on the courts,  
and it is not a mere statement of principle, but a  
statement of principle which is binding on the courts,

THE COURT: I believe you are.

THE COURT: I believe you are. I believe you are.

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Turnbull

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dosage forms of medication, such as tablets, capsules and injectables, from the basic chemical components.

THE CHAIRMAN: That does not, from my recollection, vary from the definition Mr. Conder gave us.

MR. TURNBULL: We do not consider packaging and labelling as part of the manufacturing process. We do not consider this as coming within the definition of manufacturing. It is certainly a procedure which must be given professional supervision, and very closely controlled, but not within the actual manufacture of the drug or drug preparation.

THE CHAIRMAN: Have you the gross percentage in terms of your definition? Perhaps Mr. Summers, have you got some opinion?

MR. TURNBULL: There are no available statistics to my knowledge on that. There are statistics published on the fine chemical industry, which is coming along in Canada quite well, and there are statistics related to factory sales of the pharmaceutical and medicinal industry.

PROF. SUMMERS: I have no figures, sir, but I think the one thing we are concerned about in this particular statement is primarily source, and here we are thinking particularly about the huge antibiotic industry. There is only one antibiotic at the present time being produced in Canada, and it is the source of such vital materials as these that we are concerned about.

COMMISSIONER FIRESTONE: I was glad to



various forms of medication, such as tablets, capsules  
and injectables, from the basic chemical components.  
THE CHAIRMAN: That does not, from my  
recollection, vary from the definition Mr. Conder gave  
us.

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of the drug or drug preparation.

THE CHAIRMAN: Have you the gross  
percentage in terms of your definition? Perhaps Mr.  
Turner, have you got some opinion?

MR. TURNER: There are no available  
statistics to my knowledge on that. There are statistics  
collected on the fine chemical industry, which is  
counting along in Canada quite well, and there are statis-  
tics related to factory sales of the pharmaceutical  
and medicinal industry.

THE CHAIRMAN: I have no figures, sir,  
but I think the one thing we are concerned about is  
this particular statement is primarily accurate, and how  
are we thinking particularly about the drug and medicine  
industry. There is only one exception at the present  
time, being produced in Canada, and it is the source of  
some vital materials as those that we are concerned





Turnbull

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hear you say that your Association is in favour of keeping drug prices in Canada as low as possible.

I notice you have one specific recommendation in your paragraph S-30, where you recommend the removal of the sales tax. I wonder whether you have any other proposals that would serve the same purpose?

MR. TURNBULL: We have been recommending this removal of the sales tax for many years, even while it was being increased on drugs, sir, and we would point out that this 11 million or more burden is something that we feel should not be thrust upon patients, particularly at a time when their ability to earn is possibly reduced.

The matter of drug prices, as we indicate in our brief, does not, in our opinion, have the significance that has possibly been built up over the past several years.



hear you say that your Association is in favour of  
keeping drug prices in Canada as low as possible.

I notice you have one specific treatment  
factor in your strategy, 2-3, where you recommend the  
removal of the sales tax. I wonder whether you have  
any other proposals that would save the same percentage  
of the sales tax. We have been recommending  
this removal of the sales tax for many years, ever since  
it was being increased on drugs, sir, and we would  
point out that this 11 million or more dollars is some-  
thing that we feel should not be thrust upon patients,  
particularly at a time when their ability to earn is  
being reduced.

The matter of drug prices, as we  
indicate in our brief, does not, in our opinion, have  
the significance that has possibly been built up over  
the past several years.



Turnbull

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L/dpw

We do acknowledge that drugs and the provision and purchase of pharmaceutical service may be a burden on certain segments of the population but not for the population as a whole. Actually the history of drug prices is one of reducing prices.

I do not think, and I don't think that members of the Association feel, that there is any great chance of any other reduction in drug prices as when some prices come down, the drug is on the market for a while, there are new drugs being introduced, and these new drugs are superior to the drugs presently on the market. Quite often, they are a bit expensive, but they will be used, and therefore the total drug bill is going to continue to remain at the same level.

Possibly, too, we might consider that even with a substantial reduction of drug prices, let us say, 25%, this will be felt mainly by those who are presently unable to pay, the welfare groups that have to be looked after, or the chronic patients. The chronic patient is possibly spending, say, \$200 a year. A 25% reduction is going to bring this down to \$150 a year, and perhaps there that is still too high.

But to the ordinary Canadian citizen, the 25% could conceivably represent \$2, \$2 a year.

However, we will find, too, as indicated to me, and in our main submission we have made reference to equal prices for equal quantity and quality. In our discussion of institutional purchasing of drugs as opposed to the purchasing of the same drugs by pharmacies - if one price level does come into being, I am saying





the provision and purchase of pharmaceutical services may be a burden on certain segments of the population but not on the population as a whole. Actually the history of drug prices is one of reducing prices.

I do not think, and I don't think that points of the Association feel, that there is any great chance of any other reduction in drug prices as when some prices come down, the drug is on the market for a while, there are new drugs being introduced,

and these new drugs are superior to the drugs presently on the market. Quite often, they are a bit expensive, but they will be used, and therefore the total drug bill is going to continue to remain at the same level, possibly, too, we might consider that

even with a substantial reduction of drug prices, let us say, 50%, this will be felt mainly by those who are presently unable to pay, the welfare groups that have to be looked after, on the chronic patients. The chronic patient is possibly spending, say, \$200 a year.

A 50% reduction is going to bring this down to \$100 a year, and perhaps there that is still too high.

But to the ordinary casual patient,

the 50% could conceivably represent 25, 30 a year.

However, we will have, too, as indicated to me, and in our main situation we have more reference to social progress for equal quantity and quality. In our situation of social progress, we have a lot of things to be done to be done by the government, I am saying



Turnbull

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the principle of one price level, not the price, we must consider that this is going to substantially increase the price at which hospitals and other government institutions buy drugs and at the same time reduce the price being paid by the ambulatory patient.

THE CHAIRMAN: We had an interesting suggestion made to us; the \$2 professional fee as a way of reducing the price of the more costly drugs, and the effect would be to increase the cost of the minimum price of drugs. Are you familiar with the suggestion that the Ontario College of Pharmacy put forward?

MR. TURNBULL: Yes, sir.

THE CHAIRMAN: What is the view of the Canadian Pharmaceutical Association as to that suggestion?

MR. TURNBULL: On page 116, we deal with prescription pricing practices as they are known to us, and reference is made to the most prevalent system in existence today, a system based on pricing on normal commercial mark-up plus a small professional fee.

THE CHAIRMAN: The idea is to get out of being merchants altogether, professional people altogether, and charge a dispensing fee in the dispensing of prescriptions, and the suggestion was \$2. I take it that wasn't put forward as a fixed, as a frozen, figure, but the idea being to have a professional fee tacked on the actual laid-in cost, the cost?

MR. TURNBULL: The Association, as such,



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the principle of one price level, not the price, we must consider that this is going to substantially increase the price at which hospitals and other government institutions buy drugs and at the same time reduce the price being paid by the retail pharmacy.

THE CHAIRMAN: We had an interesting

suggestion made to us; the 12 professional fee as a way of reducing the price of the more costly drugs, and the effect would be to increase the cost of the minimum price of drugs. Are you familiar with the suggestion that the Ontario College of Pharmacy put forward?

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THE CHAIRMAN: What is the view of the

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system in existence today, a system based on pricing

on a commercial basis plus a small professional

THE CHAIRMAN: The idea is to get out

of being worried together, professional people

altogether, and charge a discounting fee in the dispensing

of prescriptions, and the suggestion was \$2.50

and it wasn't put forward as a fixed, as a fixed,

figure, but the idea being to have a professional fee

added on the actual in-in cost, the cost.

MR. TURNBULL: The Association, as such,





Turnbull

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has made no statement concerning this particular thing. However, the members of the Association have viewed this method of pricing prescriptions, and I may say they have not viewed it with disfavour. Both philosophies of pricing prescriptions we feel require, and are very worthy of, study.

The professional fee concept of pricing is in existence in quite a few pharmacies in certain areas across Canada now. This would have the effect of reducing the higher-priced prescriptions, and they were in the upper 20% of prescriptions, while at the same time, to some extent, slightly increasing lower-priced prescriptions today.

One of the difficulties will be establishing a definition of cost. What is cost? Is it invoice cost or is it invoice cost plus a certain amount, electric lights, what is normal warehousing overhead? This will always be one of the difficulties here.

And I believe at the \$2 professional fee level the prescription price or the total prescription bill for the nation will be about the same, although it will reduce the higher-priced prescription.

THE CHAIRMAN: The idea is that it is the higher-priced prescriptions that are causing the difficulty?

MR. TURNBULL: These are the ones that hurt.

THE CHAIRMAN: These are the ones that are hardest to pay for?



has been a constant concern this question of  
however, the members of the Association have  
this matter of which I am speaking, and I say  
they have not viewed it with disfavor. Both the  
society of mining, and also the coal industry, and  
the coal industry.

The Association has a number of principles  
is its existence in order to have a few members in certain  
areas of the country. This would have the effect  
of reducing the higher-grade production, and they  
were in the lower grades of production, while at the  
same time, to some extent, slightly increasing lower-  
grade production today.

One of the difficulties will be  
establishing a definition of cost. What is cost? Is  
it invoice cost or is it invoice cost plus a certain  
amount, shipping freight, what is normal warehouse  
expense? This will always be one of the difficulties.

Now I believe as the \$1 production  
the level of production price on the total production  
from this the action will be about the same,  
although it will reduce the in normal production.  
The Association has been in the coal field in  
the highest and lowest prices that are known to  
the industry.

The Association has been in the coal field in  
the highest and lowest prices that are known to  
the industry.



Turnbull

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COMMISSIONER FIRESTONE: Mr. Turnbull,  
in paragraph S-45, you say that you have recommended  
to drug manufacturers:

"... that strict control over sampling  
be exercised and, within limits,  
carried out only to those physicians  
or institutions who request a quantity  
of the preparation for experimental  
or investigational purposes."

I take it this recommendation has been  
based on the basis of your concern of unnecessary  
promotional efforts. Is that the reason for making  
that recommendation?

MR. TURNBULL: Not only the unnecessary  
promotional efforts, as you say, but it is also to  
reduce the wastefulness in sampling procedures, the  
many dangers in sampling procedures that are done in  
excessive quantities. Also, we indicate in our presen-  
tation that sampling is often very detrimental to inter-  
professional relations as well as to public relations,  
of the pharmacist with the patient, and we feel that  
adequate sampling can be done to identify the product  
to the practising physician and, at the same time,  
where a physician or an institution requests a quantity  
for further investigation or for trial or experimental  
purposes in keeping with the practice of that physician  
or institution, then such procedures are most logical.

COMMISSIONER FIRESTONE: You also say,  
Mr. Turnbull, in paragraph S.46, that your Association

"... is of the opinion that





in paragraph 8-15, you say that you have recommended  
no drug administration:

"... that strict control over sampling

be exercised and, within limits,

carried out only to those physicians

or institutions who request a quantity

at the preparation for experimental

or investigational purposes "

I take it this recommendation has been

based on the basis of your concept of unnecessary

promotional efforts. Is that the reason for making

Dr. TURKUS: Not only the unnecessary

promotional efforts, as you say, but it is also to

reduce the wastefulness in sampling procedures, the

very object in sampling procedures that are done in

excessive quantities. Also, we indicate in our exam-

ination that sampling is often very detrimental to inter-

professional relations as well as to public relations.

of the interaction with the patient, and we feel that

absolute control can be done to identify the product

to the physician, pharmacist etc., at the same time,

where a physician or an institution requests a quantity

for further investigation or for the use of experimental

purposes in keeping with the guidelines of the practice

on institution, then such procedures are most logical.

Dr. TURKUS: In paragraph 8-15, you have indicated for

... is of the kind of...



Turnbull

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pharmaceutical advertising can be  
at least conducted efficiently and benefi-  
cially with a complete absence of  
undesirable frills."

Again, I take it that the objection  
against such frills in advertising is that you consider  
them wasteful?

MR. TURNBULL: - There have been claims  
in a particular area, I don't believe before this  
group, but particularly before the Restrictive Trade  
Practices Commission hearings on drug distribution in  
Canada, that there were many unnecessary frills to  
the promotion of pharmaceutical products.

If such exists, they might well be  
eliminated and stick to the business of the day.

COMMISSIONER FIRESTONE: If the objec-  
tive is to eliminate wasteful or too many samples or  
frills in advertising, or what-have-you, would your  
Association support government policies which would be  
designed to encourage the drug manufacturer to avoid  
such wasteful promotional activities?

MR. TURNBULL: Are you suggesting  
legislation or merely the encouragement?

COMMISSIONER FIRESTONE: Well, I  
could visualize an example of achieving this objective  
through taxation. For example, by declaring promotional  
expenditures which are wasteful and are frills in the  
concept you are using your report, that such expenditures  
would not be allowed as deductible expenditures under  
the Income Tax Act, and in that way the companies which



completely first-hand and in-  
directly with a complete absence of

Again, I take it that the objection

against such a bill in advertising is that you consider  
it wasteful

Mr. T. J. Sullivan: There have been claims

in advertising, and I don't believe before this  
group, but particularly before the Executive Trade  
Commission, as regards the distribution in  
Canada, that there were many unnecessary bills to  
the promotion of pharmaceutical products.

I am sure, the right bill to

eliminated and stick to the business of the day.

COMMISSIONER FINCHAM: If the objec-

tive is to eliminate wasteful or too many supplies in  
advertising, or what-ever-you, would you  
association support Government policies which would be  
designed to encourage the drug manufacturers to

and we will encourage activities

MR. FINCHAM: Now you say, waiting

local drug stores, and so on.

COMMISSIONER FINCHAM: Well, I

could visualize an example of achieving this a better  
method of advertising, for example, by developing promotional

expenditures which are wasted and the bill is in the

country, you are using your money, that your expenditures

you can be allowed as deductibles for expenditures under

the income tax act, and in that way, you can have





Turnbull

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insisted on proceeding with such frills and wastefulness, at least they would be paying 100 cents out of the dollar instead of 50 cents out of the dollar.

COMMISSIONER McCUTCHEON: It would certainly keep the lawyers busy.

COMMISSIONER FIRESTONE: These companies would be able to reduce prices because they would be devoting less money to promotional activities which appear to be wasteful or frills.

MR. TURNBULL: Well, Professor Firestone, I don't think I am qualified to comment on this. I would hate to get involved in the adjudication of income tax statements, because a frill to one person is not a frill to another; and I think we must consider, from the dollar and cent viewpoint, that where what might be termed undesirable frills are in existence, they are only a minor part of the dollar expenditure on the full promotional program of a company.

If a company is involved in, shall we say - and this has been pointed out as one of these frills - of passing out a notebook that the physician, calendar notebook, that the physician could carry around in his pocket; that this is a frill in promotion, the expense involved in this I don't think is very much of the overall picture.

COMMISSIONER FIRESTONE: Mr. Turnbull, we don't want to trouble you with offering this Commission advice on the details of how you would develop such policies. All I was trying to understand was how the objective which you seem to outline in this



interested in getting along with such firms and organizations,  
at least they would be getting out of the  
business in a few days out of the dollar.

WILLIAMSON: I would

probably have the same plan.

COMMISSIONER WILLIAMSON: These

companies would be able to reduce prices because they  
would be doing less money to promotional activities  
which appear to be wasteful on their part.

MR. TURNBULL: Well, Professor Williamson

I don't think I am qualified to comment on this. I

would have to get involved in the adjustment of  
income tax statements, because a bill to one person  
is not a bill to another; and I think we must consider  
from the dollar and cent viewpoint, that where what  
might be termed undesirable bills are in existence,  
they are only a minor part of the dollar expenditures  
on the full promotional program of a company.

If a company is involved in, and is  
say - and this has been pointed out as one of these  
bills - or passing out a notebook with the word "bill",  
certain notebook, that the physician could carry  
around in his pocket; that this is a bill in promotion,  
the expense involved in this I can estimate as very  
much of the overall picture.

We don't want to trouble you with a feeling this  
is a very serious matter of the dollar. I know you would  
be very much interested. All I was trying to understand  
was how the objective would you feel to get the bill



ANGUS. STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Turnbull

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paragraph which I have quoted - and there are several others which I haven't quoted - you seem to suggest that there appears to be certain wasteful effort, and my question is: what can we do, either by means of encouragement or taxation or other means, to achieve the objective of avoiding wasteful promotional effort?

MR. TURNBULL: Yes. I believe there are methods of doing this. Number one, the Drug Directorate publishes an administrative directive concerning the advertising and promotion of drugs in Canada; and, second, such recommendations can be made from an administrative level, not necessarily a legislative level.





...which I have ... and there are several  
... which I have ... - you seem to be  
... there appears to be another wonderful effort  
... question is: what can we do, armed by means of  
... to achieve  
... the objective of avoiding material promotional effort?  
... Yes. I believe there  
... are methods of doing this. Further on, the same method  
... separate published in administrative directive concerning  
... the advertisement and promotion of drugs in Canada; and,  
... on that, such recommendations can be made from an admini-  
... strative level, not necessarily a legislative level.



/PM/hm 1

Turnbull

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4 Secondly, there are ways in which  
5 the members of an association, a manufacturers'  
6 association be it one that represents some 60 or so  
7 companies or another that represents the balance of  
8 manufacturing firms in Canada, can say to one another  
9 "These are undesirable procedures and maybe we should  
10 stop them". I think that could be very effective pro-  
11 vided they do it but if A stops and B continues doing  
12 it then A is liable to start again.

13 COMMISSIONER FIRESTONE: I take it  
14 from what you said that you are in favour of the  
15 principle and you would hope that the Commission can  
16 think of ways and means this principle can be translated  
17 into practice.

18 MR. TURNBULL: If you can we would  
19 be pleased to assist you in its implementation.

20 COMMISSIONER FIRESTONE: Thank you  
21 very much.

22 COMMISSIONER McCUTCHEON: In connection  
23 with what you said a moment ago, you pointed out the  
24 difficulty of agreement amongst manufacturers to limit  
25 advertising in the event of A observing the limitation  
26 and B not observing it and your suggestion is that A  
27 would then start again; why would A start if this is  
28 wasteful and frivolous?

29 MR. TURNBULL: If it has an effect  
30 on the general revenue I believe that he would start  
again.

COMMISSIONER McCUTCHEON: That is a  
point. You are not sitting here and saying that the



Secondly, there are ways in which

the members of an association, a man, a woman,

association, no it one that represents some of the

concerned in another that represents the balance of

concerned in another that represents the balance of

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COMMISSIONER WILSON: I take it

from what you said that you are in favour of the

principle and you would have that the Commission can

bring of laws and means this principle can be translated

into practice.

MR. TURNER: It can be done.

be pleased to assist you in its implementation.

COMMISSIONER WILSON: Thank you

very much.

COMMISSIONER WILSON: I am

with what you said a moment ago, you pointed out the

difficulty of agreement amongst members to limit

the right in the event of a change in the situation

and a not observing it and you suggested that a

committee should be set up; why would a committee be set

up to do that?

MR. TURNER: It is a

and the committee would be I believe that is what I

COMMISSIONER WILSON: That is a

point, for the not setting up a committee that





Turnbull

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4 manufacturers of drugs are deliberately throwing money  
5 out the window?

6 MR. TURNBULL: I would definitely say  
7 they are not throwing money out the window and if they  
8 are they are most foolish.

9 COMMISSIONER McCUTCHEON: I think you  
10 have used some very loose adjectives there. That is  
11 all I will say.

12 THE CHAIRMAN: Mr. Turnbull, have  
13 you any views to express on this condition that we were  
14 told of about one detailman for every 12 practising  
15 doctors in Canada? We were told they also canvass the  
16 druggists but by the same token we were told most of  
17 their time was spent with the doctors. Have you any  
18 views to express on that? One in twelve, my rather  
19 poor and simple arithmetic says that it is likely to  
20 be that it means each doctor has a detailman on his  
21 tail for 30 days a year. From your experience in the  
22 drug industry -- they tell us that the cost is in the  
23 neighbourhood of \$12 million a year, about 12% of the  
24 manufacturers' sales cost in Canada?

25 MR. TURNBULL: No, I think here once  
26 again it involves activities of the manufacturer under-  
27 taken because he feels this could be to his economic  
28 advantage to employ such people to carry his message  
29 to the medical practitioner.

30 THE CHAIRMAN: If one does it the other  
must do it, I suppose that is the basis?

MR. TURNBULL: Yes, it certainly  
contributes to a degree to the cost of medicine in Canada,





Turnbull

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3 I presume, because Canada is a very vast nation with  
4 a lot of small communities and this has its effect on  
5 the number of people that have to be employed in some  
6 of our western provinces as well.

7 THE CHAIRMAN: Mr. Conder said that,  
8 I know, but it is a little difficult to appreciate that  
9 it takes days to travel from Saskatoon to Regina with  
10 two doctors between.

11 MR. TURNBULL: I am a native of  
12 Saskatchewan as well and several of my classmates are  
13 detailmen and I do know that they put many hundreds  
14 of miles on their cars each day. I think that they  
15 possibly have quite a greater task than, shall we say,  
16 their colleague who might be here in Medical Arts  
17 Building in Toronto. This whole picture, we agree with  
18 the previous presentation that the detailman should be  
19 a pharmacist where he is devoting his attention to the  
20 dissemination of information and, to some extent, the  
21 education of the practitioners in the area. We do not  
22 agree that where his activities are in the main sales  
23 activities he need be a pharmacist. Now, most of these  
24 people have combined jobs but the majority of their  
25 time must be spent with the medical representation work  
26 and sales is on the side as far as writing actual orders.  
27 They are, of course, a ready source of information and  
28 supply in the area and actually a consultant on many  
29 of the matters pertaining to the availability of  
30 pharmaceuticals not only from his own company, his own  
head office but through various distributing centres  
in the area. This is important to the practitioner.





I presume, because Canada is a very vast nation with a lot of small communities and this has its effect on the number of people that have to be employed in some of our western provinces as well.

MR. CHAIRMAN: Mr. Gordon said that,

I know, but it is a little difficult to appreciate that it takes days to travel from Saskatoon to Regina with two doctors between.

MR. CHAIRMAN: I am a native of

Saskatchewan as well and several of my classmates are stationed and I do know that they put many hundreds of miles on their cars each day. I think that they possibly have quite a greater task than, shall we say, their colleagues who might be here in Medical Arts building in Toronto. This whole picture, we agree with the previous presentation that the Captain should be a pharmacist where he is devoting his attention to the dissemination of information and, to some extent, the education of the practitioners in the area. We do not sense that where his activities are in the main sales activities he need be a pharmacist. Now, most of these

people have considerable jobs but the majority of their time must be spent with the medical representation work and sales as far as writing, actual orders, they are, of course, a ready source of information and help in the area and really a consultant to many of the doctors pertaining to the availability of their products not only from his own company, his own local office but through various distributing centres in the area. This is important to the practitioners.



Turnbull

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4 THE CHAIRMAN: I am only putting it  
5 this way; we have heard all across the country there is  
6 a shortage of pharmacists, they have to spend more money  
7 for more buildings, more staff, more colleges and take  
8 the product of four complete years and not one of them  
9 goes into the pharmacy business. Supposing we did the  
10 same thing -- let us move into another field -- supposing  
11 we did the same thing with all the doctors, take the  
12 product of four years from all the medical schools and  
13 not one of them went to practise medicine. Would some-  
14 body not be entitled to take, at least, a look at the  
15 justification for the expenditure of millions of dollars  
16 to accomplish what must from that standpoint be  
17 regarded as an ancillary activity?

18  
19 MR. TURNBULL: I think there is another  
20 point we must look at here.

21  
22 THE CHAIRMAN: Do they have these  
23 detailmen in England or is this an American manifesta-  
24 tion of publicity and merchandising?

25  
26 MR. TURNBULL: Not on a one in twelve  
27 scale but detailmen do exist in Great Britain.

28  
29 THE CHAIRMAN: The only difference  
30 between Canada and the United States is that the pro-  
portion in Canada is one to twelve and in the United  
States it is one to ten?

MR. TURNBULL: Yes, I understand in  
Europe the pharmaceutical companies use men with an M.D.  
degree on the continent to a greater extent.

THE CHAIRMAN: One might be prepared  
to observe that then perhaps they should pay for their



THE CHAIRMAN: I am only putting it  
 this way: we have heard all across the country there is  
 a shortage of pharmacists, they have to spend more money  
 for more buildings, more staff, more colleges and take  
 the product of four complete years and not one of them  
 goes into the pharmacy business. Supposing we did the  
 same thing -- let us move into another field -- supposing  
 we did the same thing with all the doctors, take the  
 product of four years from all the medical schools and  
 not one of them went to practise medicine. Would some-  
 body not be entitled to take, at least, a look at the  
 justification for the expenditures of millions of dollars  
 to accomplish what must from that standpoint be

repeated as an ancillary activity?  
 MR. TURNER: I think there is another  
 point we must look at here.

THE CHAIRMAN: Do they have these  
 definitions in England or is this an American manifesta-  
 tion of political and philosophical  
 MR. TURNER: Not on a one in twelve

scale but definition as exist in Great Britain.  
 THE CHAIRMAN: The only difference  
 between Canada and the United States is that the pro-  
 portion in Canada is one to twelve and in the United  
 States it is one to ten?

MR. TURNER: Yes, I understand in  
 Europe the pharmaceutical companies are men with an M.D.  
 license on the continent to a greater extent.  
 THE CHAIRMAN: One might be prepared  
 to suppose that these people should pay for their





Turnbull

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3 education.

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5 MR. TURNBULL: Of course, this is a  
6 personal matter with the person who enters the detailing  
7 field. I think I might say nobody enters the pharma-  
8 ceutical detailing field on the assumption that he is  
9 going to be there for the remainder of his life. This  
10 is, shall we say, a step, step number one in his process  
11 of going up to the management level within the pharma-  
12 ceutical firm. There are only a certain number of  
13 openings in manufacturing laboratories and production  
14 work and our experience is that there are very few  
15 production and control and laboratory people move up  
16 into managerial positions in industry whereas this man  
is starting basically in the field force and starting  
up.

17 DEAN MATTHEWS: I would like to add  
18 to that that much to the annoyance, I believe, of many  
19 of the pharmaceutical manufacturing firms there is a  
20 very high percentage of these people that after a short  
21 period of time working as detailmen they go back into  
22 a retail pharmacy. They look upon this as an experience  
23 and they can either move into the managerial and  
24 administration work in the industry or go back into a  
25 retail pharmacy and use this experience to their own  
benefit in business.

26 I would like to go back to another  
27 point that you were making earlier about the utilization  
28 of pharmacists' services and I would say there is another  
29 avenue that has great possibilities, in my view, for  
30 correcting the situation. We feel people in the academic



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MR. MATTHEWS: I would like to ask so that much to the advantage, I believe, of many of the pharmaceutical manufacturing firms there is a very high percentage of these people that after a short period of time working as detailers they go back into a retail pharmacy. They look upon this as an experience and they can either move into the managerial and administrative work in the industry or go back into retail pharmacy and use this experience to their own benefit in business.

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Turnbull

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3 field that we are turning out, graduates in pharmacy,  
4 can be consulted by the physicians on many of these  
5 things that a pharmaceutical sales representative can-  
6 not do. If they can accomplish this inter-professional  
7 relationship to the point where physicians will utilize  
8 this service to a greater degree and consult their  
9 pharmacists in their own community to a great degree  
10 I can see this helping to solve the one in twelve ratio  
11 because it will lessen the economic advantage to the  
12 manufacturer if the physician is using a local pharmacist  
more.

13 THE CHAIRMAN: Thank you very much.

14 COMMISSIONER BALTZAN: Does this  
15 obtain now? This last question that was put to you  
16 or that you raised, do not physicians frequently consult  
17 pharmacists about various products and their pharma-  
ceutical action?

18 DEAN MATTHEWS: I would say to an  
19 increasing degree and we hope it will increase still  
20 more because I think there are many physicians who do  
21 this fairly regularly but there are others who do not  
22 take advantage of it.

23 COMMISSIONER BALTZAN: I do not want  
24 to detain you but I would like to speak to Mr. Turnbull  
25 regarding a statement on page 19, paragraph 63 at the  
26 top of the page:

27 "While this association does not  
28 "look with favour .... are readily  
"available."

29 The only explanation I want, if you  
30





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top of the page:

"While this association does not

"look with favour . . . and readily

"avail itself."

"The only explanation I want, if you



Turnbull

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4 please, when you say pharmaceutical service you refer to  
5 prescriptions or do you also refer to supplies, such  
6 things as bandages, trusses and other things?

7 MR. TURNBULL: Our reference to  
8 pharmaceutical services would be prescribed drugs and  
9 therapeutic appliances.

10 COMMISSIONER BALTZAN: Now, when you  
11 say it has been necessary to have controls, what are  
12 these controls? What is meant by "control"?  
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prescriptions or do you also refer to supplies, such  
things as bandages, crutches and other things?  
MR. TROTT: Our reference to  
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COMMISSIONER BALLMAN: Now, when you  
say it has been necessary to have controls, what are  
these controls? What is meant by "control"?





Turnbull

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B/dpw

MR. TURNBULL: In this particular context we were discussing and using the word deterrent or the word deterrent fee. We are thinking here of a fee at the time service is rendered or which is payable at the time service is rendered which would prevent any abuse of a program being brought about by the demands of the users of the program, what we consider as being outside our definition of pharmaceutical service; that is in lesser items, the normal household drugs and bandages and this type of thing.

On the other hand, this definition or terminology of deterrent fee could be extended to patient participation fee and when you get in that, into the sphere of patient participation, it is a form of recognition by the patient of the service being rendered and it is a form of payment for the service when rendered, a co-insurance payment made at the time.

COMMISSIONER BALTZAN: I understand that. I have great difficulty in understanding this, I submit it to you; when the patient receives a prescription it must be taken for granted that the prescription was necessary?

MR. TURNBULL: Right.

COMMISSIONER BALTZAN: In the opinion of the doctor, etc., so as long as that is necessary it should not be discontinued; am I right?

MR. TURNBULL: Correct.

COMMISSIONER BALTZAN: In what way can there be an abuse of that prescription that that patient



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Turnbull

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needs when it is given to him by a doctor if the deterrents are to avoid over-utilization? I asked that before.

MR. TURNBULL: We don't believe we have made reference to the possibilities of over-utilization.

COMMISSIONER BALTZAN: Not in your case, but I am putting the proposition to you.

MR. TURNBULL: Yes. This, however, is brought about by the influence which the patient has upon the busy practitioner. I think, sir, that this may properly be acknowledged, the influence to obtain quantities of a preparation which the prescribing physician may decide the patient could well use, but the patient has been the influencing factor in rendering the service.

COMMISSIONER McCUTCHEON: In other words, it will do him no harm, make him happy?

MR. TURNBULL: At the same time, on a co-insurance basis you are establishing the acknowledgment of the value of the service and are not creating - you are creating influences which work against the over-demand by the user of the service or services.

THE CHAIRMAN: Professor Summers?

PROF. SUMMERS: Could I say something, sir? What we are trying to say basically is this: that any plan that we know of where it has started out by unlimited drug coverage we have found that over-utilization has arisen to a degree where it has alarmed those who are paying for the service.





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COMMISSIONER MONTGOMERY: In other

words, it will do him no harm, make him happy?

MR. TURNBULL: At the same time, on a

corollary basis you are establishing the acknowledgment  
 of the value of the service and not cheating - you  
 are creating influences which work against the over-  
 utilization on the part of the service or services.

THE CHAIRMAN: Professor Summers.

PROF. SUMMERS: Could I say something,

sir? What we are trying to say basically is that: that  
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Summers

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Immediately this happened they began to apply controls to the system. This worked hardships, it is true, both upon the prescriber and the patient.

Now, why this has happened we are not prepared to say, except that they have turned around and put on controls either on participating payment by the patient or by restricting the drugs which the physician may prescribe. We would hate to see this happen. We wouldn't like to see this happen. It has happened in all other systems we know about.

THE CHAIRMAN: Including the Green Shield Plan at Windsor?

PROF. SUMMERS: That is right, sir, and what has happened, for example, in England; they turned around and put a 2/-d. payment on a prescription and the public looks upon the pharmacist as a tax collector and this is an unenviable position to be in.

THE CHAIRMAN: That is what he is.

PROF. SUMMERS: That is what he is, exactly.

COMMISSIONER BALTZAN: Would you agree to another type of deterrent, that is to prescribe better drugs?

DEAN MITCHELL: That would do it all right.

THE CHAIRMAN: Mr. Turnbull, on page 9, S.23, where you refer to the brand versus generic name controversy, without going over what you have said and appreciating what your position is, you think there really isn't much merit in what has been said, but I



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THE CHAIRMAN: Including the Green

field plan at Winston

1901. SUMNER: That's right, sir, and

what has happened, for example, in England; they turned  
around and put a 10-15 percent on a prescription and the  
load upon the physician as a tax collector and this  
is an undesirable position to be in.

THE CHAIRMAN: That is what he is.

1902. SUMNER: That is what he is.

THE CHAIRMAN: Would you agree

to another type of control, that is to prescribe

rather than

1903. SUMNER: That would do it all

THE CHAIRMAN: In England, in fact,

1904. SUMNER: Wherever you go to the same system prevails  
and, however, if you go to the same system you have all the  
same kind of control, you have a prescription, but I  
really don't think it is worth the trouble, but I





Turnbull

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just want to draw to your attention for the purpose of having your opinion, what was said to us by the spokesman for the Canadian Society of Hospital Pharmacists who appeared before us here last week, and which is, as I recall, he said that the use of the formulary in a hospital worked most satisfactorily and gave the hospital pharmacist no difficulty.

A hospital pharmacist is just another pharmacist working in a hospital instead of working in a retail drugstore. Why should it give him no difficulty and you say it is impractical, impossible and so forth, etc., in the retail drugstore?

MR. TURNBULL: We do not indicate that it is impossible. However, I think we have to consider ---

THE CHAIRMAN: You do not recommend it, certainly.

MR. TURNBULL: No, sir. In hospital practice you have a formulary system as opposed - there are formularies in existence in some hospitals but the formulary system which, in essence, has been created and is workable through the intimate contact between the physician and pharmacist within that institution.

THE CHAIRMAN: It is still the same physician in that same area who is working in the hospital in the area, is it not?

MR. TURNBULL: It has institutional authorization, however.

THE CHAIRMAN: We know all that. This has been told us and repeated yet we find a man who is



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has been told us and repeated yet we find a man who is



Turnbull

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working at Point A saying "I can, without difficulty, without danger and so forth, use a formulary system, substitute generic drugs for brand name drugs and the patient does not suffer." You say that it ought not be done in a retail pharmacy a block away or across the street. What is the answer? If there is an answer we want to hear it because these people seem quite sincere and they are a branch of your profession.

MR. TURNBULL: Certainly; and we certainly go along with what they have said. In an institution the formulary system appears to be a most workable system. It may work to the disadvantage of some manufacturers, but that, sir, is not our concern.

However, outside the hospital in the community, and I might say, the physician is agreeing to this when he is granted practising privileges in the institution. This is one of the things he agrees to when he is given the privilege.

THE CHAIRMAN: He is the same physician.

MR. TURNBULL: He may not agree with it, but he agrees to it.

THE CHAIRMAN: He is the same physician in the same community?

MR. TURNBULL: That is correct. Are you suggesting in the community, the community pharmacist in that area, should, shall we say, adopt the same formulary as has been adopted in the hospital?

THE CHAIRMAN: In the hospital.

MR. TURNBULL: In that community. We would run into difficulty right there with five





Continued

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THE CHAIRMAN: Is it the same situation?

DR. TUCKER: He may not agree with it,

but he agrees to it.

THE CHAIRMAN: Is it the same situation

in the same community?

DR. TUCKER: That is a matter.

You suggest in the community, the community program

is in that case, should, shall we say, adopt the

same formulary as has been adopted in the hospital?

THE CHAIRMAN: In the hospital.

DR. TUCKER: In that community.

Would you like to discuss it further?



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hospitals close to one another in Toronto. These are five hospitals which have different drugs that they accept, under their particular formulary system and which they dispense on the prescriptions, possibly some of these prescriptions written by the same physician who practises in one or more hospital.

THE CHAIRMAN: Let us stay, in a nice little community that has one hospital. Toronto, against all that is said, is not the rest of Canada.

MR. TURNBULL: I agree with that. In the community that has one hospital and the physicians of the community are all in agreement, that they are ready...

THE CHAIRMAN: Whether they are in agreement or not they are on the staff of this hospital.

MR. TURNBULL: I imagine in community practice.

THE CHAIRMAN: Yes.

MR. TURNBULL: If they are ready and willing to subrogate their opinion concerning the efficacy of drug preparations and their opinion, I presume, has been gathered with experience and through experience, the results they have experienced and they learn to expect from the prescribing of a particular, shall we say, brand or manufacturer's product. If they are prepared to do this on an individual basis there is nothing to say it would not work, sir.

PROF. SUMMERS: I think the crux of the thing is this: in the hospitals, in actual fact, it is the medical staff who agree to put in the formulary



hospital close to one another in Toronto. There are  
five hospitals which have different drugs that they  
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Summers

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system. It is not the hospital. It is not the pharmacist. It is not the director of the hospital. It is the pharmacy and therapeutic committee of the medical staff. They turn to the pharmacist and say, "Prepare a formulary." They approve it. There is nothing to say that a particular group of physicians outside of the hospital could not do the same thing.

THE CHAIRMAN: I am going to suggest: do you think the reason is because they are propagandized at the rate of 30 days a year by individual manufacturers to do otherwise.

PROF. SUMMERS: I would not be prepared to say, sir. I think it is a question which, perhaps, they might answer.

THE CHAIRMAN: Is that really the answer to it?

MR. TURNBULL: I think experience will probably indicate the answer to this. Where a new preparation, a new drug, comes onto the market, the practising physician possibly uses the product of the company which he has had good experience with on previous occasions.

My own pharmacy experience is this: that if he doesn't get what he considers desired results out of that manufacturer's particular preparation, even on the first, not worrying about the second or third time, he switches the brand and once he finds a brand that gives the response he may expect, he sticks with it because this is what he wants to produce; that is the effect he wants to produce and whether he is right or



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On own pharmacy experience is this: that it is doesn't let what he could not justify, even out of their responsibility. Particular in marketing, even in the first, not working about the second or third time, he switches the brand and there is times a brand that gives the response he has expected, or rather with it. He is not willing to produce and whether it is right or



Turnbull

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wrong in his choice he thinks he is right.

DEAN MATTHEWS: I think this is one of the important factors that hasn't been brought out before. In this formulary system you don't accept all preparations having the same ingredients, even in the same dose, are essentially therapeutic equivalents but you only have one pharmacy and one stock.

If you are in a community where there are more doctors and more pharmacists they will not have the same stock, and therefore in the present free enterprise system, unless you can tell them all to have the same stock, there are going to be differences of brands, which will not occur in a hospital where you have one controlled stock.

Assuming these products are not therapeutic equivalents, this other thing Mr. Turnbull mentioned is going to develop. I am not saying there isn't a remedy for this, but this is an uncontrollable factor in this problem.





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Turnbull

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THE CHAIRMAN: What is the experience coming out of Alberta since the Act was proclaimed on the 5th of April permitting druggists to substitute a generic drug for a brand name drug unless countermanded to do so by the physician?

MR. TURNBULL: I don't believe that there has been sufficient time. That was assented to early in April. Possibly Mr. McKeague, who is practising in Calgary, can add to that.

MR. McKEAGUE: There really has not been sufficient time to indicate what the effect overall will be, but my own practice, and I operate two professional pharmacies in medical buildings, there has been no change whatever in the prescribing habits of, I would say, 95% of the doctors, with this exception: that several of them have, because the Act has now changed their responsibility, are stamping their prescriptions, or writing on it: "No substitution".

THE CHAIRMAN: Are they doing that, or are they using the prepared tags, furnished by the manufacturing companies, with that printed on them?

MR. McKEAGUE: No, they are not, sir.

THE CHAIRMAN: We have heard that that was being done.

MR. McKEAGUE: I have seen that once and have seen one pad of it, but they are not using them.

I think there is another basic difference that has not been brought out. In a hospital formulary system the patients are under strict



THE CHAIRMAN: What is the experience coming out of Alberta since the Act was proclaimed on the 5th of April permitting druggists to substitute a generic drug for a brand name drug unless counter-indicated to do so by the physician?

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McKeague

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supervision. They are not under as strict supervision in public practice, and it has traditionally been the doctor's prerogative to use what he wishes, and certainly he is influenced by the experience of the products of certain companies, maybe against non-brand companies, but the fact that they agree to do it in the hospitals, I don't think we would ever get them to agree to do it in public practice.

I cannot see myself going to the doctors in my building and saying: "I don't care what you order; this is what you are going to get." I would lose my business.

THE CHAIRMAN: Thank you very much, gentlemen. I hope that this way of handling it has not been too cumbersome for you. It has been of some advantage to us.

MR. MITCHELL: Mr. Chairman, I would like to thank you, and through you, the members of your Commission, for your sympathetic hearing, and I think understandable hearing, on the behalf of our Association.

I want to quite honestly thank you for this opportunity.

THE CHAIRMAN: We must, very frankly, say that we are obliged to the Conference of Pharmaceutical Faculties and to the Canadian Pharmaceutical Association for these two briefs, which contain a great deal of material which is of great value to us, and the mere fact that we may have certain questions that seem to imply we don't think much of some ideas does not necessarily mean just where we are going, because we put



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as we want the opinions and the reactions of the people  
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--- Short Recess





THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1947

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Very truly yours,

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THE CHAIRMAN: If we may come to order please.

THE SECRETARY: The next submission, Mr. Chairman, will be by Dr. Raphael and it will be Exhibit 323.

--- EXHIBIT NO. 323: Submission of Dr. S.S. Raphael.

SUBMISSION OF DR. S.S. RAPHAEL

Appearance: Dr. S.S. Raphael

THE CHAIRMAN: You may remain seated, Dr. Raphael, if you will.

DR. RAPHAEL: Thank you, sir. I am presenting this brief as a private citizen, and it relates to the British National Health Service and it does not have a direct relationship with the Canadian scene, except as I have explained in the first part, that during the hearings of this Commission I believe there have been briefs presented which, to my mind, have suggested that in this country we adopt a similar scheme to what is presently running in Great Britain.

THE CHAIRMAN: Well, a number of people have suggested to that effect.

DR. RAPHAEL: I believe this is important to do, because in so many respects this country shares many things with Great Britain, and it seems almost as if we go on sharing things, because it is Britain and Canada, and sometimes it would pay us better to look into what is happening.

I, myself, was born, raised and educated



11-23

THE CHAIRMAN: If we may come to order

THE CHAIRMAN: The next admission,

Mr. Goodman, will be by Dr. Raphael and it will be

--- EXHIBIT NO. 323: Submission of Dr. S.S. Raphael.

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Raphael

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2  
3 in Great Britain and I came here to Canada in 1955,  
4 although I had spent some time previously in the  
5 United States.

6 information. For the last four or five years I  
7 have attempted, in what spare time I have, to study  
8 the National Health Service and to try and understand  
9 something of its history, of its structure, of its  
10 function and how it has come up to its expectations  
11 and after this time my study leads me to believe  
12 certain things.

13 It leads me to believe that the insti-  
14 tution of a free health service increases the demand  
15 for the use of health services.

16 available to us? THE CHAIRMAN: What you mean is a non-  
17 contributory; when you use the word "free", are you  
18 using it synonymous with non-contributory?

19 DR. RAPHAEL: I mean free at the time  
20 of usage. It leads me to believe that the facilities  
21 in the British National Health Service, although great  
22 things were promised, have, after all this time, after  
23 14 years, remained more or less unaltered.

24 It has also shown me that there is an  
25 increase in the number of people who have shown some  
26 dissatisfaction in this system of State medicine that  
27 some people in this country would have us adopt. It  
28 has shown me that statistically the health of the  
29 British people is no better now than it was in 1948,  
30 and what improvements there have been are more or less  
the same as have been in any other western country.

THE CHAIRMAN: Well now, in that regard,



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THE CHAIRMAN: What you mean is a non-  
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and what improvements there have been are more or less  
the same as have been in any other western country.

THE CHAIRMAN: Well now, in that regard,



Raphael

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you have tabulated a number of things.

DR. RAPHAEL: Yes.

THE CHAIRMAN: Have you any statistical information on that very point?

DR. RAPHAEL: I don't have it in this brief, sir, no.

THE CHAIRMAN: Of morbidity and incidence of illness, and mortality, and so forth?

DR. RAPHAEL: Yes.

THE CHAIRMAN: You say you have it, but not in the brief?

DR. RAPHAEL: That is right, sir.

THE CHAIRMAN: Could you make it available to us?

DR. RAPHAEL: Yes, sir.

THE CHAIRMAN: I don't know if you were here this morning, but that was one of the questions that we were discussing here this morning when the system in the United Kingdom was being recommended.

DR. RAPHAEL: I also have some reason to believe that there has been an increase of professional discontent, which has shown itself amongst different groups of people practising in the medical field, and especially amongst physicians and I do believe after my studies into it, that in a sense it is irreversible, and that once a country has adopted this type of system, then it is on these particular rails, and with other than some major upheaval, very little seems to be able to be done to alter it.





THE CHAIRMAN: Have you any statistical

information on that very point?

MR. RABALAIS: I don't have it in this

brief, sir, no.

THE CHAIRMAN: On confidants and their

degrees of interest, and loyalty, and so forth.

MR. RABALAIS: Yes.

THE CHAIRMAN: You say you have it,

but not in the brief?

MR. RABALAIS: That is right, sir.

THE CHAIRMAN: Could you make it

available to us?

THE CHAIRMAN: I don't know if you

were here this morning, but that was one of the

questions that we were discussing here this morning.

When the system in the United Kingdom was first

started,

it was a very simple system.

to believe that there had been an increase of professional

discontent, which has shown itself in various

forms of social protest, in the case of the U.S. and

especially in the case of the U.S. and I do believe that

my studies indicate that in a sense it is the opposite.

and that since a country has started this type of system,

then it is on these grounds that it is, and that it is

in some way, in a sense, that it is to be able

to be able to give it.



Raphael

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THE CHAIRMAN: Was what happened in Great Britain, the inauguration of the National Health Service Bill in 1946, the introduction of the Bill, really much of a departure from what had been coming forward from the early 1900's?

DR. RAPHAEL: No, it was a continuation of what had happened in 1911, in a sense, and this went on, and aided, as it were, by the reformist atmosphere engendered by the war, the medical scheme of 1911, as it were, was enlarged into the British National Health Service.

It is a long process, but it stems right back until that time.

THE CHAIRMAN: And to what extent is still the old 1911 philosophy governing the situation?

DR. RAPHAEL: I think, sir, it is governing it quite a lot. For example, when the National Health Service Scheme started, the forms weren't ready and the forms we used were the old N.H.I. forms from the previous panel scheme, the 1911 scheme.

One of the great promises of the National Health Service was the organization of general medical practice, which had fallen into some disrepute and it was promised that health centres would be built and more doctors would be working in these, and so on, but in actual fact the doctors are still practising more or less as they were, and more or less as the Act of 1911 had made them practise.

For example, in this country it is not uncommon to find a general practitioner with equipment



THE CHAIRMAN: What was that happened in

Great Britain, the inauguration of the National Health Service Bill in 1946, the introduction of the Bill, really much of a departure from what had been coming forward from the early 1930's?

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more or less as they were, and more or less as the Act

of 1911 had more than provided.

For example, in this country it is not

uncommon to find a general practitioner with equipment





Raphael

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such as electrocardiograms, or a little laboratory where he can do tests, attached to his office. He generally has a secretary and other features like this but these things are more or less very uncommon in Great Britain, because the Act of 1911 made the general practitioner a doctor with limitations.

He was to provide a particular type of service and so he was bound within those obligations and general practice became contracted within those and so, strangely enough, one of the promises of the National Health Service was to get him out of this but in actual fact it just continued it along.

THE CHAIRMAN: Your background in medicine; are you practising as a physician or a surgeon?

DR. RAPHAEL: As a pathologist.

THE CHAIRMAN: And you were practising pathology in Great Britain before you came?

DR. RAPHAEL: I did training in pathology before I came to Canada.

THE CHAIRMAN: What is the situation there regarding the young physician who has taken post-graduate work, and is ready to specialize? What are the openings? I mean, what is the procedure? How does he get into business?

DR. RAPHAEL: Well, shall we start from the time he graduates?

THE CHAIRMAN: Yes.

DR. RAPHAEL: He graduates and then he does one year compulsory internship, and then he does



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of service and so he was bound within those obligations

and general practice became concentrated in those

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but in actual fact it just continued in being.

THE CHAIRMAN: Your background in

medicine; are you practically as a physician or a

surgeon?

MR. KILPATRICK: As a pathologist

THE CHAIRMAN: And you were practicing

pathology in Great Britain before you came?

MR. KILPATRICK: I did training in

pathology before I came to Canada.

THE CHAIRMAN: What is the situation

there regarding the young physician who has taken post-

graduate work, and is ready to specialize? What are

the opportunities? I mean, what is the procedure? How does

he get into his specialty?

MR. KILPATRICK: Well, what we want

from the time he graduated

THE CHAIRMAN: Yes.

MR. KILPATRICK: The specialties are in an

one-year compulsory internship, and then he does



Raphael

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two years as a registrar, and then he will do four years as a senior registrar. The registrar periods are more or less what you would call residence in North America, except that in Great Britain they carry a much greater degree of responsibility, and usually by the time a man has done his two years registrarship he has got higher qualifications, but he goes on, so he has six years as a registrar. Then he is in a position to apply for a vacancy as a consultant surgeon or physician.

THE CHAIRMAN: Does he get some certification, or become a member of the Royal College?

DR. RAPHAEL: He has had this for several years already. He probably wouldn't be appointed senior registrar unless certified. Then he applies for an advertised vacancy as consultant in his specialty, and he has to be chosen from the particular number of people who apply.

THE CHAIRMAN: Supposing there are no advertised vacancies?

DR. RAPHAEL: Then he stays where he is, or he leaves.

THE CHAIRMAN: If he leaves he must go somewhere. Where does he go?

DR. RAPHAEL: He must go abroad. It is inconceivable that he can start private practice, because he would have no hospital privileges and being a specialist he would need hospital privileges, and therefore, if there is no vacancy and he cannot hang on long enough, logically he must leave the country,





two years as a registrar, and then he will be four years as a senior registrar. The registrar periods are more or less what you would call residence in North America, except that in Great Britain they carry a much greater degree of responsibility, and usually by the time a man has done his two years' registrarship he has got higher qualifications, but he goes on, so he has six years as a registrar. Then he is in a position to apply for a vacancy as a consultant surgeon or physician.

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because he would have no hospital privileges and

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and therefore, if there is no vacancy he cannot

leave his hospital, logically he must leave the country,



Raphael

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I suppose.

THE CHAIRMAN: And do some leave the country? Is that the solution for some, or do they just hang on?

DR. RAPHAEL: Well, sir, recently there has been a great deal of writing about how many have left the country and Dr. Seal maintains that one-third of the British output of students, annual output, is now leaving the country.

THE CHAIRMAN: I suppose you know that his figures have been challenged in some quarters?

DR. RAPHAEL: Yes, I do know that.

THE CHAIRMAN: On the basis that there were a number of students who went in intending to leave?

DR. RAPHAEL: Yes, but when I look round a small town in Canada I am inclined to believe his figures rather than wonder if his figures are incorrect. There are other figures, of course. There are the figures of a Dr. Davidson, which were published particularly about Canada.

Perhaps you have heard about these?

THE CHAIRMAN: For the moment I cannot say that I have, but I have heard so much that that wouldn't mean that we haven't been told of them.

DR. RAPHAEL: I just have it here. I will try not to prolong you, but the point he makes, according to Canadian Government figures, 1,104 British doctors emigrated to Canada during the past five years; that is the years 1955 to 1959, and these are the



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THE CHAIRMAN: Now do you leave the

country? Is that the situation now, or to the

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say that I have, and I have heard so much that that

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DR. RABINOVITZ: I just gave it now. I

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according to Canadian Government figures, 1,100 British

students emigrated to Canada during the past five years;

but in the years 1955 to 1959, and these are the





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Raphael

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official figures from the Canadian Government.

The doctor-patient ratio in British emigrants coming to Canada is one doctor with every 196 British emigrants.

THE CHAIRMAN: They are going to be well taken care of anyway.

COMMISSIONER BALTZAN: You seem to be very knowledgeable on this subject. Has the specialization, the number of specialists, the ratio increased over that of the number of general practitioners?



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Raphael

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DR. RAPHAEL: If I could answer your question in one word, it would be yes.

COMMISSIONER BALTZAN: That is all I want to know.

DR. RAPHAEL: But it is a qualified yes.

COMMISSIONER BALTZAN: I have heard that before.

You mentioned increased utilization of services.

DR. RAPHAEL: Yes.

COMMISSIONER BALTZAN: Has that levelled off at all, do you know?

DR. RAPHAEL: Yes, it has levelled off. But it has levelled off because of the imposition of financial deterrents, I think.

COMMISSIONER BALTZAN: You don't use the words, or do you use the words, "increased utilization" as synonymous with "over-utilization". For instance, people may have gone now because they couldn't go before, so it would be an increased utilization. On the other hand, other people may be going just to take advantage, let's use that word.

DR. RAPHAEL: I think it would be very difficult to tell which was which. But if I could give a numerical example between the years 1950 and 1957. Now, this would be two and a half years after the National Health Service came into being and presumably the great rush that everybody talks about was over. Now, if we take something appropos what the gentlemen previously





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DR. RAFAEL: If I could answer your

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COMMISSIONER BALTIMORE: What is all

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we have something approaches what the situation was previously



Raphael

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4 were talking about, pharmaceutical supplies, in 1950  
5 there were 217 million prescriptions, and in 1957 there  
6 were 207 million, which is a drop of about 4.6%.

7 Now, in New Zealand, which has a  
8 similar service but which has no financial deterrents,  
9 the figures for the same years are 7.24 million and  
10 12.56 million which is an increase of 73.5%. So in  
11 the one country there is a decrease of 4.6% and in the  
12 other country an increase of 73.5%, and the only  
13 difference in the two countries is the institution of  
14 financial deterrents in the one.

15 COMMISSIONER BALTZAN: Thank you.  
16 That is all I want to ask.

17 COMMISSIONER McCUTCHEON: Dr. Raphael,  
18 talking to the people in the pharmaceutical business  
19 today and several days previously, the term of  
20 "prescription drugs" has been used, and in my own mind  
21 I may have misunderstood. I assumed that this would be  
22 drugs which could only be obtained on prescription,  
23 the type of drugs which are provided under the health  
24 plans that we hear about in other countries. But I  
25 notice that on page 18 of your brief you say that in  
26 1958 of the total N.H.S. prescriptions 38.4% could be  
27 considered household remedies, tonics, and so on.

28 DR. RAPHAEL: Yes.

29 COMMISSIONER McCUTCHEON: If the  
30 price is in my favour, if I go to the physician in  
England to get 100 aspirins, I can get them for two  
shillings instead of five shillings?

DR. RAPHAEL: Yes, you could go and get

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James

were talking about, pharmaceutical supplies, in 1955 there were 117 million prescriptions, and in 1957 there were 120 million, which is a drop of about 4.6%.

Now, in New Zealand, which has a similar service but which has no financial deterrents, the figures for the same years are 7.24 million and 12.56 million which is an increase of 73.3% and in the one country there is a decrease of 4.6% and in the other country an increase of 73.3%, and the only difference in the two countries is the institution of financial deterrents in the one.

COMMISSIONER BATTAN: Thank you.

That is all I want to ask.

talking to the people in the pharmaceutical business today and several days previously, the term of "prescription drugs" has been used, and in my own mind I may have misunderstood. I assume that this would be drugs which could only be obtained on prescription, the type of drugs which are provided under the health plans that we hear about in other countries. But I notice that on page 16 of your report you say that in 1955 of the total 11.8, prescriptions 10.4% could be considered household remedies, tonics, and so on.

COMMISSIONER BATTAN: Yes, that is

what is in my report, if I do to the physician in England to get 100 aspirins, can get them for two shillings instead of five shillings?

MR. BATTAN: Yes, you could do that.





Raphael

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4 it. Well, I spent a year in general practice in Great  
5 Britain. I couldn't talk of the situation as of this  
6 moment, but certainly this did happen, people would come  
7 in and say: "I want 100 aspirins."

8 COMMISSIONER McCUTCHEON: And like  
9 a good doctor you gave them a prescription which wouldn't  
10 do them any harm?

11 DR. RAPHAEL: You were under a certain  
12 pressure, because if you didn't give it they would take  
13 their cards. I didn't own this practice, but I was  
14 told by the principal of the practice: "Give them  
15 anything they like or else they will take away their  
16 cards." Say a man has five cards, a wife and three  
17 children, if they don't get what they want they will  
18 take away their cards.

19 COMMISSIONER McCUTCHEON: Doctors are  
20 human and they are subject to that sort of pressure?

21 DR. RAPHAEL: Only too human, sir.

22 COMMISSIONER GIRARD: I see what  
23 prevails in Canada prevails also in Great Britain. Great  
24 Britain is losing nurses to Canada also.

25 DR. RAPHAEL: Yes.

26 COMMISSIONER GIRARD: What provision  
27 is there for anyone in hospital in England to get  
28 special nursing or private duty nursing?

29 DR. RAPHAEL: I think if they were  
30 admitted to a ward bed there wouldn't be any possibility  
of private nursing. I think they could only get what  
we call private nursing in pay beds.

COMMISSIONER GIRARD: If they were



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 Britain. I wouldn't talk of the satisfaction of this  
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 anything they like or else they will take their  
 cards." Say a man has five cards, a wife and three  
 children, if they don't get what they want they will

human and they are subject to that sort of pressure?

DR. RATHBURN: Only for men, say,

COMMISSIONER GIBSON: I see what

prevails in Canada practice also in Great Britain. Great  
 Britain is losing nurses to Canada also.

COMMISSIONER GIBSON: What provision

is there for anyone in need of in England to get

special training or private duty nursing?

DR. RATHBURN: I think it is very

difficult to a great extent there wouldn't be any possibility  
 of private nursing. I think they could only get what  
 is called private nursing in private.

COMMISSIONER GIBSON: The fact that



Raphael

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4 in a ward bed and were very critically ill, and I  
5 understand there is a shortage of nurses there, too,  
6 say the doctor would want them to have special care, they  
7 would still have to share the one nurse with three or  
8 four or five patients, according to the nurses per  
9 patient?

10 DR. RAPHAEL: Yes, I think so.

11 COMMISSIONER GIRARD: This is not as  
12 good as what we have here, because we can, if the patient  
13 needs it, get special nursing.

14 DR. RAPHAEL: Yes.

15 COMMISSIONER BALTZAN: You used the  
16 words "paid bed".

17 DR. RAPHAEL: Yes.

18 COMMISSIONER BALTZAN: Would you  
19 explain that? This is rather novel.

20 DR. RAPHAEL: Private room. There  
21 are about 4,000 or 5,000 private beds in British public  
22 hospitals which are private rooms, you pay to use them.

23 COMMISSIONER BALTZAN: There is an  
24 extra fee for that particular thing?

25 DR. RAPHAEL: Yes. They are quite  
26 high fees.

27 COMMISSIONER BALTZAN: How high?

28 DR. RAPHAEL: When I left, I think it  
29 was in the neighbourhood of about 20 guineas a week,  
30 which would have been about \$60.00 a week for merely  
the use of the room, which by British standards was  
quite expensive.

COMMISSIONER McCUTCHEON: Dr. Raphael,





in a ward bed and were very critically ill, and I  
understand there is a shortage of nurses there, too,  
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would still have to share the one nurse with three or  
four or five patients, according to the nurses per

DR. FAIRBANK: Yes, I think so.  
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extra fee for that particular thing?  
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high fees.

COMMISSIONER BARTON: How high?  
DR. FAIRBANK: When I left, I think it  
was in the neighborhood of about 20 pounds a week,  
which would have been about \$20.00 a week for merely  
the use of the room, which in British standards was  
quite enormous.



Raphael.

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there are doctors who are in private practice, are there not?

DR. RAPHAEL: Yes. There are about 500 private practitioners at the moment, I believe.

COMMISSIONER McCUTCHEON: How are they able to make a living?

DR. RAPHAEL: There has been a remarkable growth of people who desire private medical care. Initially that was mainly for specialists, and, in fact -- I am not sure that all I say you haven't heard, but I have no reason to know that, of course -- there are some companies who sell private insurance and they have increased, the biggest one, from 60,000 in 1948 to, at the moment, I read, 902,000 people, and in all the private insurance companies now cover something like a million and a quarter people of Great Britain, which is about two and a half per cent of the population. Initially they only sold private specialist care insurance, but in the last two years they are beginning now to sell general practitioner private care. In addition to those people who take out private medical insurance, there is a large number of people who, although they pay to the plan and they stick their stamps in the book, when they go to the doctor they will pay them. There is a number of people do that, especially people in the wealthier suburbs, wealthier areas.

COMMISSIONER McCUTCHEON: Can I go into a restricted area and set up private practice?

DR. RAPHAEL: Yes.



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There are doctors who are in private practice, and there

Dr. [Name] [Address] [City] [State] [Zip]

200 private practitioners at the moment, I believe.

Now, [Name] [Address] [City] [State] [Zip]

able to make a living?

Dr. [Name] [Address] [City] [State] [Zip]

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heard, but I have no reason to know that, of course --

there are some companies who sell private insurance and

they have increased, the highest one, from 10,000 in

1948 to, at the moment, I read, 30,000 people, and

in all the private insurance companies now cover something

like a million and a quarter people of Great Britain,

which is about 10 and a half per cent of the population.

Initially they only sold private medical as a

insurance, but in the last two years they are beginning

now to sell general practitioner private care, in

addition to those people who take out private medical

insurance, there is a large number of people who,

although they pay to the plan and they still

remain in the pool, when they go to the doctor they will

pay them. There is a number of people who that,

especially people in the western world, whether

...

Continued on page 2

into a restricted area and so on, and so on.

Dr. [Name] [Address] [City] [State] [Zip]





Raphael

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4 COMMISSIONER McCUTCHEON: I can go  
5 anywhere I want and take my chance?

6 DR. RAPHAEL: Yes.

7 THE CHAIRMAN: Thank you very much,  
8 Dr. Raphael.

9 DR. RAPHAEL: Thank you, sir.

10 THE CHAIRMAN: We have not discussed  
11 this detail in the brief, but you have the factual  
12 material here and it is going to be very valuable to us.

13 DR. RAPHAEL: I am most grateful, sir.

14 THE CHAIRMAN: Now we have the  
15 Canadian Association of Medical Record Librarians, and  
16 Mrs. Jelaffke will be the spokesman. This will be  
17 number 324.

18 ---EXHIBIT NO. 324:

19 Submission of The Canadian  
20 Association of Medical  
21 Record Librarians.  
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COMMISSIONER: Yes, I can do

anywhere I want and take my chance?

THE CHAIRMAN: Thank you very much,

DR. RAPHAEL: Thank you, sir.

THE CHAIRMAN: We have not discussed

this detail in the brief, but you have the material here and it is going to be very valuable to us.

DR. RAPHAEL: I am most grateful, sir.

THE CHAIRMAN: Now we have the

Canadian Association of Medical Research Laboratories, and

Mr. Lafitte will be the secretary. There will be

number 124.

Secretary of the Canadian  
Association of Medical

---LAFITTE NO. 124:



SUBMISSION OF  
THE CANADIAN ASSOCIATION OF MEDICAL  
RECORD LIBRARIANS

APPEARANCES:

Mrs. M.A. Jelaffke  
Miss M. Wilson  
Mrs. J. Milner  
Rev. Sister Mary Paul

MRS. JELAFFKE: Mr. Chairman, members of the Royal Commission on Health Services, may I be permitted to introduce the representatives of our Association.

Reverend Sister Mary Paul, Director of School for Medical Record Librarians, St. Michael's Hospital, Toronto; Mrs. Milner, Business Secretary and Registrar of the Canadian Association of Medical Record Librarians, and Miss Wilson, Chairman of the Board of Registration of the Association.

THE CHAIRMAN: You are the medical record people. We had another association, group, in connection with medical libraries here last week, but you are in another field.

MRS. JELAFFKE: Yes. However, some of our members do have to attend to the medical libraries within their hospitals as well.

The Canadian Association of Medical Librarians is grateful for the opportunity to submit the following brief to the Royal Commission on Health Services and to attend its hearings. It is hoped that the presentation of this brief will clarify the role of the Medical Record Librarian as a member of the Health





COMMISSION OF  
THE CANADIAN ASSOCIATION OF MEDICAL  
LIBRARIANS

Mrs. M.A. Jelliffe  
Miss M. Wilson

ADJUTANT:

of the Royal Commission on Health Services, may I be  
permitted to introduce the representatives of our

Reverend Sister Mary Paul, Director  
of School for Medical Record Librarians, St. Michael's

and Registrar of the Canadian Association of Medical  
Record Librarians, and Miss Wilson, Chairman of the Board  
of Registration of the Association.

THE CHAIRMAN: You are the medical  
record people. We had another association, group, in  
connection with medical librarians here last week, but  
you are in another field.

MRS. JELLIFFE: Yes. However, some  
of our members do have to attend to the medical librarians  
within their hospitals as well.

The Canadian Association of Medical  
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following brief to the Royal Commission on Health  
Services and to attend its hearings. It is hoped that  
the presentation of this brief will clarify the role of  
the Medical Record Librarian as a member of the Health



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Care Team in Canada.

The Content of this brief will include the following subjects:

1. The Formation and Aims of the Canadian Association of Medical Record Librarians;
2. The Role of the Medical Record Librarian in the Health Field;
3. The Present Training Programme for Medical Record Librarians;
4. The Existing Shortage of Registered Medical Record Librarians in Canada and the Recommendations to Meet this Need.

1. The Formation and Aims of the Canadian Association of Medical Record Librarians

The Canadian Association of Medical Record Librarians was formed in 1942 and obtained its Dominion Charter in 1949. The aims, as set out in the Constitution by By-Laws, are:

- a) To elevate the standard of clinical records in hospitals, dispensaries or other distinctly medical institutions;
- b) To provide means for acquiring and disseminating among the members facts and opinions useful to them;
- c) To provide means for exchanging ideas and intercommunication among such members;
- d) To establish and maintain a registry of medical record librarians;
- e) To do any other things that may be conducive to the rendering of intelligent service by the



Case Team in Canada.

The Content of this brief will include

the following subjects:

1. The Formation and Aims of the Canadian Association of Medical Record Librarians;
2. The Role of the Medical Record Librarian in the Health Field;
3. The Present Training Programme for Medical Record Librarians;
4. The Existing Shortage of Registered Medical Record Librarians in Canada and the Recommendations to Meet this Need.

Medical Record Librarians

Record Librarians was formed in 1942 and obtained its Dominion Charter in 1949. The aims, as set out in the Constitution by Spilars, are:

- a) To elevate the standard of clinical records in hospitals, dispensaries or other distinctly medical institutions;
- b) To provide means for acquiring and disseminating among the members facts and opinions useful to them;
- c) To provide means for exchanging ideas and intercommunication among such members;
- d) To establish and maintain a registry of medical record librarians;
- e) To do any other things that may be conducive to the rendering of intelligent service by the





persons aforesaid in hospitals, dispensaries or other distinctly medical institutions, or that may be conducive to the objects aforesaid.

2. The Role of the Medical Record Librarian in the Health Field

Medical Record Librarians serve in direct medical care programs and related enterprises all over the world. In hospitals and clinics, they work alongside members of the clinical staffs and other medical specialists reviewing, co-ordinating and organizing their manifold reports for most effective immediate and future use.

3. The Present Training Programme for Medical Record Librarians

There are presently eleven (11) approved schools, not affiliated with Schools of Medicine, operating in hospitals in Canada which provide a formal twelve (12) month course for Medical Record Librarians leading to Registration in the Canadian Association of Medical Record Librarians. Professional status is accorded the properly qualified Medical Record Librarian. She becomes Chief of an important Hospital Department, working among professional people.

4. The Existing Shortage of Registered Medical Record Librarians in Canada and the Recommendations to Meet this Need

The existing shortage of Registered Medical Record Librarians is evidenced by the fact that,



persons appearing in hospitals, dispensaries or other  
distinctly medical institutions, or that may be confined  
to the subject generally.

## 2. The Role of the Medical Record Librarian in the

Medical Record Librarian serves in  
direct medical care programs and related enterprises all  
over the world. In hospitals and clinics, they work  
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acquired the property qualified Medical Record Librarians.  
The person Chief of an important hospital department  
working among professional people.

## 4. The Existing Shortage of Medical Record Librarians

Librarians in Canada and the Government's Role in

Meeting This Need

The existing shortage of Medical Record Librarians is evidenced by the fact that



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4 as of 1961, of the 1,354 hospitals in Canada, only 251  
5 were able to obtain the services of Registered Medical  
6 Record Librarians. This demonstrates the fact that  
7 1,103 Registered Medical Record Librarians are needed  
8 to provide each of the remaining hospitals with the  
9 services of one Registered Medical Record Librarian.  
10 If these figures are based on the assumption that a  
11 general hospital should have one librarian for every  
12 100 beds, then, in reality, many librarians in addition  
13 to the minimum of 1,103 will be required to adequately  
14 staff hospitals in Canada.

15 Recommendations to overcome this shortage:

16 Affiliation with Schools of Medicine

- 17 a. Would permit greater number of enrol-  
18 ment than would additional schools for Medical Record  
19 Librarians in hospitals;  
20 b. Lectures would be centralized;  
21 c. Facilities for training Medical Record  
22 Librarian students would be available in hospitals  
23 employing graduates of approved schools;  
24 d. Sequential correlation between lecture  
25 and practical assignment would be made possible;  
26 e. One centralized practical arts room  
27 with up-to-date equipment and processing of medical  
28 record data would replace the necessity of individual  
29 hospitals maintaining demonstration rooms;  
30 f. Affiliation with Schools of Medicine  
would raise the professional standing and remuneration  
of the Medical Record Librarian, thus encouraging university







Jelaffke

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students to major in Medical Record Library Science leading to a Bachelor of Science (B.Sc.) degree;

g. could be done. In keeping with the above, it is imperative that post graduate Teachers' Course for Registered Medical Record Librarians be established and maintained.

#### CONCLUSION

This summary points out the need for more Registered Medical Record Librarians and training facilities. The present number of Medical Record Librarians is totally incapable of adequately staffing Medical Record Departments of hospitals in Canada. In order to overcome this need, and provide the service for which Registered Medical Record Librarians are trained, a source of financial assistance, possibly through Government grants and/or bursaries is necessary.



reference to the National Record Library Service, and  
to a meeting of the National Record Library Service,  
in 1954, it is  
imperative that the National Record Library Service  
be established and  
maintained.

It is a primary responsibility of the Government  
to establish a National Record Library Service and training  
facilities. The present number of National Record  
Librarians is totally inadequate to adequately staff  
National Record Libraries in Canada. In  
order to overcome this need, and provide the services  
for which registered medical record librarians are trained,  
a source of financial assistance, possibly through  
Government grants and/or donations is necessary.





PM/hm

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4 THE CHAIRMAN: Thank you very much,  
5 Mrs. Jelaffke. I am going to suggest that Dr. Baltzan  
6 should develop this subject. All I know about medical  
7 libraries is that I used to have a room in a hospital  
8 and they took it away from me and gave it to the  
9 librarian.

10 other people do. COMMISSIONER BALTZAN: It is a very  
11 important modern function of every modern hospital.  
12 First, do you as medical record librarians all serve  
13 in hospital libraries or is that a separate function?

14 MRS. JELAFFKE: This is different in  
15 each hospital, I suppose. However, due to the lack of  
16 medical librarians in many hospital which I am familiar  
17 with the medical record librarian is also given the  
18 responsibility of looking after the medical library  
19 which is quite common.

20 COMMISSIONER BALTZAN: There is often,  
21 of necessity, a dual function?

22 MRS. JELAFFKE: That is correct.

23 COMMISSIONER BALTZAN: In any one  
24 hospital would one hospital librarian be enough or  
25 how do you pro-rate the number of librarians in the  
26 records office related to the size of the hospital?

27 THE CHAIRMAN: You suggested one for  
28 every 100 beds?

29 MRS. JELAFFKE: Yes, that figure has  
30 been given. Figures have been quoted based on the  
number of discharges.

COMMISSIONER BALTZAN: What I had in  
mind, with all due regard to these figures, I have this  
sort of thing in mind: Take the usual records in our



THE CHAIRMAN: That's very much, Mrs. Delaney. I am going to suggest that Mr. Ballman should develop this subject. All I know about medical librarians is that I used to have a room in a hospital and they took it away from me and gave it to the

COMMISSIONER BALLMAN: It is a very important modern function of every modern hospital. First, do you as medical record librarians all say in hospital librarians or is that a separate function? MRS. DELANEY: This is different in each hospital, I suppose. However, due to the lack of medical librarians in many hospitals when I am familiar with the medical record librarian is also given the responsibility of looking after the medical library which is not a common.

COMMISSIONER BALLMAN: There is often, or necessarily, a dual function?

MRS. DELANEY: That is correct. COMMISSIONER BALLMAN: In any case hospital would one hospital librarian be enough or how do you operate the number of librarians in the records office related to the size of the hospital?

THE CHAIRMAN: You suggested one for every 100 beds. MRS. DELANEY: Yes, that figure has been given. Figures have been quoted based on the number of beds.

COMMISSIONER BALLMAN: What I have this kind, with all the money to these things, I have this sort of thing in mind. The thing is in our



Jelaffke

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4 up-to-date hospitals and one will find six, seven or  
5 eight helpers in the records office. Would you want  
6 more than one librarian in charge of these people?

7 MRS. JELAFFKE: Yes.

8 COMMISSIONER BALTZAN: Would you want  
9 more than one librarian to delegate the work that these  
10 other people do in the library?

11 MRS. JELAFFKE: That is correct.

12 COMMISSIONER BALTZAN: Unfortunately  
13 a lot of record offices are doing without any at all  
14 today by about 1,000?

15 MRS. JELAFFKE: Yes.

16 THE CHAIRMAN: I have been told that  
17 the biggest headache these record librarians have is to  
18 get the doctors to write up their reports?

19 MRS. JELAFFKE: That is a real  
20 difficulty.

21 THE CHAIRMAN: Now, you speak of an  
22 association; what is your basic qualification, have you  
23 an education qualification to begin with?

24 MRS. JELAFFKE: Yes, senior matricula-  
25 tion is the minimum.

26 THE CHAIRMAN: And what type of training,  
27 what period of training?

28 MRS. JELAFFKE: The schools mentioned  
29 have a 12-month course in which they take very complete  
30 training both in theory and practical training in the  
hospital here in Toronto in St. Michael's Hospital and  
Sister Mary Paul is the director of that department.

THE CHAIRMAN: How much clinical





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up-to-date for trials and one will find six, seven or  
eight helpers in the records office. Would you want  
more than one librarian in charge of these people?

COMMISSIONER: Would you want  
more than one librarian to do the work that these  
other people do in the library?  
MR. DEAN: That is correct.

COMMISSIONER: Unfortunately  
a lot of record offices are doing without any at all  
today by about 1,000.  
MR. DEAN: Yes.

MR. DEAN: I have been told that  
the present practice these record librarians have is to  
get the doctors to write up their reports.  
MR. DEAN: That is a real

THE CHAIRMAN: Now, you speak of an  
association; what is your basic qualification, have you  
an education qualification to begin with?  
MR. DEAN: Yes, senior membership  
tion in the library.

THE CHAIRMAN: And what type of training,  
what sort of training?  
MR. DEAN: The seniors mentioned  
have a 12-month course in which they take very complete  
course in both in theory and practical training in the  
hospital here in London in St. Michael's Hospital and  
then they pass in the diploma of that department.  
MR. DEAN: What sort of clinical



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3 training, in-hospital training in a period of a year?

4 REV. SISTER MARY PAUL: Twelve months.

5 THE CHAIRMAN: The whole twelve months  
6 in the hospital?

7 REV. SISTER MARY PAUL: Yes, the  
8 students spend 12 months in the hospital.

9 THE CHAIRMAN: Is this student employed  
10 and being paid a salary?

11 REV. SISTER MARY PAUL: No, some of  
12 the students are on bursaries but that is not a salary.

13 THE CHAIRMAN: Until the year is up?

14 REV. SISTER MARY PAUL: That is right.

15 THE CHAIRMAN: And your figures here,  
16 there is no great difficulty in getting a job?

17 REV. SISTER MARY PAUL: No.

18 COMMISSIONER BALTZAN: Who provides  
19 instruction that I see here on page 6?

20 REV. SISTER MARY PAUL: Some of the  
21 instruction is taken along with the student nurses, for  
22 instance, anatomy and physiology, the students where  
23 they have that same course now take a course in  
24 bacteriology and some of the courses in medical sciences  
25 and so on.

26 THE CHAIRMAN: What is the purpose  
27 of that? They are not going to be in touch with the  
28 patient at all, is it merely a matter of learning the  
29 language?

30 REV. SISTER MARY PAUL: No sir, in  
our work one very important phase of the work is keeping  
a diagnostic index and we code disease and in order to  
help with series that a doctor asks for and so on, they



trained, hospital training in a period of a year?  
MR. SHERMAN: Yes, twelve months.  
THE CHAIRMAN: The whole twelve months

in the hospital?  
MR. SHERMAN: Yes, the  
students spend 12 months in the hospital.  
THE CHAIRMAN: Is this student employed  
and being paid a salary?

MR. SHERMAN: Yes, some of  
the students are on salaries but that is not a salary.  
THE CHAIRMAN: Until the year is up?  
MR. SHERMAN: That is right.  
THE CHAIRMAN: And your figures here,  
there is no great difficulty in getting a job?

COMMISSIONER PATTERSON: Who provides  
the position that I see here on page 62?  
MR. SHERMAN: Some of the  
instruction is taken along with the student nurses, for  
instance, anatomy and physiology, the students where  
they have that same course now take a course in  
physiology and some of the courses in medical sciences  
and so on.

THE CHAIRMAN: What is the purpose  
of that? They are not going to be in touch with the  
patient at all, is it merely a matter of learning the  
theory?  
MR. SHERMAN: No sir, in  
one word one very important part of the work is learning  
a diagnostic system and we could discuss that in order to  
help with cases that a doctor sees and so on, they





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3 must have knowledge of medical terms and must know the  
4 various diseases or what causes various diseases and  
5 so on. It is really a necessity.

6 COMMISSIONER BALTZAN: It is not just  
7 a matter of memorizing names but to know what the names  
8 stand for?

9 REV. SISTER MARY PAUL: Yes, sir.

10 THE CHAIRMAN: And in the modern  
11 hospital do you use any of the business machines for  
12 processing or carding or punching?

13 REV. SISTER MARY PAUL: There are no  
14 hospitals, to my knowledge, in Canada which use them  
15 but I do know of two or three in the United States that  
16 do have the punch card system, the I.B.M. In Canada I  
17 know of no hospital that has this.

18 COMMISSIONER VAN WART: You use  
19 microfilm?

20 REV. SISTER MARY PAUL: Yes, we do.

21 COMMISSIONER GIRARD: Have any of you  
22 started doing any work on professional activity studies  
23 in your departments?

24 REV. SISTER MARY PAUL: Well, in some  
25 of the hospitals in Canada they have introduced that  
26 system, I think there are now five but perhaps Miss  
27 Wilson could tell us about that.

28 MISS WILSON: As president of the  
29 Ontario Association of Medical Record Librarians I was  
30 asked to take part in the study on professional activities  
study on a joint committee composed of representatives  
of the Ontario Hospital Association and the Ontario



must have knowledge of medical terms and must know the  
various diseases or what causes various diseases and  
so on. It is really a necessity.

COMMISSIONER SALTMAN: It is not just  
a matter of memorizing names but to know what the names  
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REV. SISTER MARY PAUL: Yes, sir.

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processing or coding or punching?

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but I do know of two or three in the United States that  
do have the punch card system, the I.B.M. In Canada I  
know of no hospital that has this.

COMMISSIONER VAN WAT: You use

REV. SISTER MARY PAUL: Yes, we do

COMMISSIONER GILBERT: Have any of you

started doing any work on professional activity studies  
in your department?

REV. SISTER MARY PAUL: Well, in some

of the hospitals in Canada they have introduced that  
system, I think there are now five but perhaps Miss  
Wilson could tell us about that.

MISS WILSON: As president of the

Ontario Association of Medical Record Librarians I was  
asked to take part in the study on professional activities  
study on a joint committee composed of representatives  
of the Ontario Hospital Association and the Ontario



Wilson

11476

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4 Medical Association. I was asked, as a member of that  
5 committee to go back to my own association and to form  
6 a committee to study the case abstract form used by the  
7 profession activities study at Ann Harbour, Michigan.  
8 Our committee studied it thoroughly and have revised the  
9 form and have submitted it to the joint committee and  
it is now under their study.

10 COMMISSIONER GIRARD: If this becomes  
11 general routine in hospitals will you have to add some-  
12 thing to your curriculum to qualify your medical record  
13 librarian to look after this phase of the work?

14 REV. SISTER MARY PAUL: Not really  
15 because it will be an abstract. The record librarian  
16 will have to abstract from the medical record and just  
17 transfer the information to a form whereas at the moment  
18 we are doing it in various ways, we are abstracting it  
19 to certain, what we call a medical auditing form,  
20 posting it on a disease card and so on. All that will  
21 be taken care of by this punch card system or whatever  
22 system they will use. We will take that information from  
23 the abstract form which would have to be completed in  
the medical record department, that would still be one  
of our phases of work.

24 COMMISSIONER BALTZAN: I hope that all  
25 you have to abstract is typewritten, at least, not in  
26 a doctor's handwriting?

27 REV. SISTER MARY PAUL: Well, the  
28 forms we have seen just require figures and so on or  
perhaps just a check mark.

29 COMMISSIONER BALTZAN: Are you obliged  
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committee to go back to my own association and to form  
a committee to study the case abstract form used by the  
profession activities and at Ann Arbor, Michigan.  
Our committee studied it thoroughly and have revised the  
form and have submitted it to the Joint Committee and  
it is now under their study.  
COMMUNICATIONS DEPARTMENT: If this becomes  
general you are in hospitals will not have to and some-  
times to your curriculum to qualify your medical record  
librarian to look after this phase of the work.  
REV. C. F. Y. KAHN, D.D.: Not really  
because it will be an abstract. The record librarian  
will have to abstract from the medical record and place  
thereafter the information to a form whereas at the moment  
we are doing it in various ways, we are abstracting it  
to certain, what we call a medical abstract form.  
position it on a disease card and so on. All that  
be taken care of by this paper card system on whatever  
system the will use. We will take that information from  
the abstract form which would have to be completed in  
the medical record department, that would still be on  
our part of work.  
COMMUNICATIONS DEPARTMENT: I hope that all  
you have to abstract is transcription, at least, not in  
a doctor's handwriting.  
Some we have seen just medical journals and so on or  
perhaps just a check mark.  
COMMUNICATIONS DEPARTMENT: And you are tried



Wilson

11477

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3 sometimes to re-copy summaries of cases?

4 REV. SISTER MARY PAUL: Yes, we do  
5 and abstracts are made.

6 COMMISSIONER BALTZAN: That is what  
7 I had in mind.

8 COMMISSIONER VAN WART: Are your  
9 record systems uniform in all the hospitals or do hospitals  
10 have an individuality?

11 REV. SISTER MARY PAUL: Depending on  
12 the size of the hospital. There is a standard routine  
13 which must be followed in our approved hospital, there  
14 must be a system, there must be a diagnosis index,  
15 an operative index, a physician's index, the records  
16 must contain a certain amount of information to be  
17 considered adequate.

18 COMMISSIONER VAN WART: Who sets that  
19 standard, the accreditation?

20 REV. SISTER MARY PAUL: Yes.

21 COMMISSIONER VAN WART: The hospital  
22 accreditation set that standard?

23 REV. SISTER MARY PAUL: Yes.

24 COMMISSIONER VAN WART: And they are  
25 uniform in all the hospitals?

26 REV. SISTER MARY PAUL: Well, uniform  
27 just in one sense, there are various ways in which, for  
28 instance, admissions may be handled. There may be various  
29 ways in which discharges can be handled but the overall  
30 picture is uniform. You must always find in an approved  
department a system whereby records are made available  
for a study, for research and for whatever purpose --



11-11-51

...sometimes to personal knowledge of cases?  
A. YES, IN MANY CASES. YES, WE DO

and records are made  
...THAT IS WHY  
I had in mind.

...AND YOUR  
...record systems uniform in all the hospitals on the hospital  
...have an individuality

...REPLY, YES, IN MANY CASES. Depending on  
the size of the hospital. There is a standard routine  
which must be followed in our records in detail, there  
must be a system, there must be a standard index,  
in operative and, a physician's index, the records  
must contain a certain amount of information to be  
considered adequate.

...COMMISSIONER OF THE HEALTH DEPT. What is that  
standard, the classification?

...REPLY, YES, IN MANY CASES. Yes,  
...COMMISSIONER OF THE HEALTH DEPT. The hospital  
classification see that standard?

...REPLY, YES, IN MANY CASES. Yes,  
...COMMISSIONER OF THE HEALTH DEPT. And they are  
uniform in all the hospitals?

...REPLY, YES, IN MANY CASES. Well, in some  
just in one sense, there are various ways in which, for  
instance, a classification may be handled. There may be various  
ways in which diseases can be handled but the overall  
picture is the same. You must always think in an overall  
picture and a system whereby records are made and classified  
in a way, for research and for general use.





Wilson

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4 patients re-admitted and so on. There are other ways  
5 in which the routine does not necessarily have to be  
6 exactly the same, the admissions can be handled one way  
7 and the discharges in another way.

8 COMMISSIONER VAN WART: Is there much  
9 research done by the local staff in the hospitals?

10 REV. SISTER MARY PAUL: Speaking for  
11 my own hospital there is a great deal.

12 THE CHAIRMAN: You are at one of the  
13 teaching hospitals?

14 REV. SISTER MARY PAUL: Yes.

15 MISS WILSON: I am at the Toronto  
16 General and there is a great deal of research carried  
17 on.

18 MRS. JELAFFKE: I am at Queensway  
19 General Hospital which has been open for six years and  
20 this, of course, is not a teaching hospital. However,  
21 there are considerable series which we get out for the  
22 doctors, that is, they review cases in order to study  
23 particular diseases and write papers on these and gain  
24 more knowledge. Quite a bit of that is done in our  
25 hospital also.

26 COMMISSIONER VAN WART: Thank you.

27 THE CHAIRMAN: These pupils, I take  
28 it they are all girls, where do you recruit them from?  
29 Do they just come along and say "I would like to be a  
30 record librarian"?

REV. SISTER MARY PAUL: We have career  
days, the various schools for Grades XII and XIII are  
very often invited to the hospital and the various heads



patients re-admitted and so on. There are other ways in which the routine does not necessarily have to be exactly the same, the admissions can be handled one way and the discharges in another way.

COMMISSIONER VAN WART: Is there much research done by the local staff in the hospitals?

my own hospital there is a great deal.  
THE CHAIRMAN: You are at one of the teaching hospitals?

MRS. WILSON: I am at the Toronto General and there is a great deal of research carried

MRS. TELATKIN: I am at Queen'sway General Hospital which has been open for six years and this, of course, is not a teaching hospital. However, there are considerable series which we set out for the doctors, that is, they review cases in order to study particular diseases and write papers on these and gain more knowledge. Quite a bit of that is done in our hospital also.

COMMISSIONER VAN WART: Thank you.  
THE CHAIRMAN: These pupils, I take it they are all pupils, where do you recruit them from? Do they just come along and say "I would like to be a doctor"?

REV. SISTER MARY HALL: We have career days, the various students from the XII and XIII are very often invited to the hospital and the various



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TORONTO, ONTARIO

Wilson

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4 of the departments will speak to the girls and tell them  
5 what type of course is available to them in the hospital  
6 and so on. We are often invited to the high schools.  
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OFFICE OF THE SECRETARY OF THE ARMY  
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Wilson

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what type of course is available to them in the hospital  
and so on. We are often invited to the high schools.

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4 THE CHAIRMAN: Once the girl becomes  
5 interested, then she enrolls.

6 REVEREND SISTER MARY PAUL: Yes.

7 THE CHAIRMAN: Is there a fee charged?  
8 Is it a hospital service?

9 REV. SISTER MARY PAUL: There is a  
10 \$200.00 tuition fee and a \$10.00 application fee. That  
11 is the same for all hospitals. I think there is only one  
12 exception, and that is \$250.00.

13 THE CHAIRMAN: And the other costs, I  
14 suppose, are taken up by the Hospital Commission as part  
15 of the hospital budget?

16 REV. SISTER MARY PAUL: Yes, I would  
17 think so.

18 THE CHAIRMAN: There is an unlimited  
19 amount to learn about the operation of health services.

20 COMMISSIONER VAN WART: Are you  
21 associated in your regional hospitals with medical  
22 librarians, or are you just library records?

23 MRS. JELAFFKE: Many record librarians...

24 COMMISSIONER VAN WART: I mean as  
25 individuals are you associated with medical libraries  
26 in the hospitals?

27 REV. SISTER MARY PAUL: We are not.

28 MRS. JELAFFKE: No.

29 COMMISSIONER GIRARD: Miss Jelaffke,  
30 I gather one of your recommendations in this brief is  
that you would like to be associated with the schools of  
medicine instead of being schools in hospitals; is that  
right?



THE CHAIRMAN: There is a slight increase

in the cost of the service, then a small

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Jelaffke 11481

MRS. JELAFFKE: That is right.

COMMISSIONER GIRARD: Have you done anything along that line, consulting deans of the schools of medicine? Has anything been done in any of the provinces regarding this?

MRS. JELAFFKE: There hasn't been anything done by our Association as such. If I might call on Sister again, perhaps a little more could be added to this.

REV. SISTER MARY PAUL: I have to add I was invited by the Dean of Medicine to discuss this.

THE CHAIRMAN: By Dean Hamilton?

REV. SISTER MARY PAUL: Yes, it was really Dr. MacFarlane and Dr. McKerracher and Dr. McLeod.

THE CHAIRMAN: Were they talking to you on our behalf at that time or on behalf of the university?

REV. SISTER MARY PAUL: I think they were probably talking on behalf of the Royal Commission, as far as I know.

THE CHAIRMAN: And the knowledge they got will be transmitted to us.

REV. SISTER MARY PAUL: Yes.

MRS. JELAFFKE: We have also put in our brief the recommendations Sister Mary Paul made at that time with regard to affiliation with the schools of medicine.

COMMISSIONER GIRARD: Most of the reasons that you give here would be things pertaining to centralization. All the things you give for being in the



MR. CHURCH: That is right.

MR. CHURCH: Have you done

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MR. CHURCH: By Dean Hamilton?

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MR. CHURCH: Were they talking to

you on our behalf at that time or on behalf of the

university?

REV. SISTER MARY PAUL: I think they

were probably talking on behalf of the Board of Education.

as far as I know.

MR. CHURCH: And the knowledge that

you would be transmitted to us.

REV. SISTER MARY PAUL: Yes.

MR. CHURCH: We have also put in

our paper the recommendations of Sister Mary Paul more

at that time with regard to this matter with the schools

of medicine.

MR. CHURCH: I am glad to hear of

your work and you give me more things pertaining to

your work. All the things you give me help in the



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4 school of medicine you could get by a central school  
5 whether it were in a school of medicine or otherwise.  
6 If you had central school. It would permit a greater  
7 number of enrolments, lectures would be centralized,  
8 facilities would be centralized, correlation between  
9 lecture and practical assignments would be made possible  
10 with centralization, up to date equipment --- all the  
11 things could be got in a central school, all the benefits  
12 of being a school of medicine, outside of being near  
13 the doctors would be really pertinent to centralization.  
14 That was why I was wondering if you couldn't get in the  
15 schools of medicine whether you had thought of centraliza-  
16 tion. A central school would give you all these benefits.

17 REV. SISTER MARY PAUL: I think my  
18 reason for thinking the school of medicine mostly was in  
19 Indiana there is a program where other paramedical  
20 personnel are taking their courses, such as the physio-  
21 therapists, the medical technicians and so on, and they  
22 are all at the school of medicine. I think following that  
23 through there is no reason why the medical record  
24 librarians couldn't also share these lectures that would  
25 be given to other paramedical personnel.

26 COMMISSIONER GIRARD: I see your  
27 reason. I was only thinking if you cannot get this long  
28 process into the medical schools, if you couldn't you  
29 could get the same benefits by centralization, a central  
30 school where you could use the facilities of all the  
hospitals in one locality instead of you using the  
facilities of only one hospital. If it was a centralized  
school your students could have the advantage of that





school of medicine you could get by a central school  
 whether it were in a set of 12 medicine or otherwise,  
 if you had central school. It would permit a greater  
 number of appointments, lectures would be centralized,  
 facilities would be centralized, cooperation between  
 lecture and practical assignments would be made possible  
 with centralization, up to date equipment --- all the  
 things could be got in a central school, all the benefits  
 of being a school of medicine, outside of being near  
 the doctors would be really pertinent to centralization,  
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 schools of medicine whether you had thought of centraliza-  
 tion. A central school would give you all these benefits.  
 REV. DR. J. H. HALL: I think my  
 reason for thinking the school of medicine mostly was in  
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 personnel are taking their courses, such as the physio-  
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 school where you could use the facilities of all the  
 hospitals in one facility instead of you having the  
 facilities of only one hospital. It is a centralized  
 school where students could have the advantage of all



Rev. Sister 11482

work and at the same time you could correlate lectures with field work.

COMMISSIONER BALTZAN: Just one question: How proficient and well trained is a person who has taken this course of one year? The reason why I ask that is because you also indicate that you would like to have some proceed on to a university degree. Is that necessary? While it might be fine, it is necessary? Are these girls at the end of twelve months ready to do the job?

REV. SISTER MARY PAUL: We recommend at the school that if it is a young girl just coming from high school with no other training, with no other experience, that she would go to a hospital as an assistant or else just in a very small hospital until she has had another year or two of experience. It is quite a responsibility to assume at the age of 19 or 20. We feel by a year's experience in a larger hospital as an assistant or at a very small hospital she will be able to get experience.

COMMISSIONER GIRARD: When you suggest she could get a degree, there is no degree such as the medical library science, is there?

REV. SISTER MARY PAUL: They do in the United States.

COMMISSIONER GIRARD: But here in Canada?

REV. SISTER MARY PAUL: We have none.

COMMISSIONER GIRARD: That is what I thought.



work and at the same time you could correlate lectures with field work.

COMMISSIONER: Let me ask one

question: How proficient and well trained is a person who has taken this course of one year? The reason why I ask that is because you also indicate that you would like to have some proceed on to a university degree. Is that necessary? While it might be fine, it is necessary? Are these girls at the end of twelve months ready to do the job?

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COMMISSIONER: But have in

REV. SISTER MARY PAUL: We have in

COMMISSIONER: That is what I

thought.





Rev. Sister 11483

REV. SISTER MARY PAUL: We have no schools affiliated with the university at all.

MRS. MILNER: We do grant registration through our own Association to our own graduates who pass our own registration examinations in a similar way that the nursing profession would.

MISS JELAFFKE: We mentioned the registered medical record librarian.

COMMISSIONER GIRARD: If the student goes to the university she gets some university sciences, but no medical library science.

REV. SISTER MARY PAUL: As it is now, we have no course affiliated with the university.

COMMISSIONER GIRARD: I think it is a wonderful thing for nurses also. You mentioned in here someplace you accept persons with senior matriculation or registered nurses. I wouldn't want to see too many registered nurses after spending three years become medical librarians. We need them too much. I have sent some nurses into the medical library field. I had a nurse with polio and she couldn't do the same type of work after and she has worked out very well as a medical record librarian.

MRS. JELAFFKE: There are quite a number of medical record librarians who are registered nurses.

THE CHAIRMAN: Thank you very much, Sister Mary Paul, Mrs. Jelaffke and ladies. You have come at the end of the day. We have kept you waiting and you were very gracious to accept our invitation to



1948

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schools affiliated with the university at all.

REV. J. M. GALT: We are great registration

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our own registration examination in a similar way that

REV. J. M. GALT: We mentioned the

COMMISSIONER: GALT: It the student

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COMMISSIONER: GALT: I think it is a

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report you accept persons with senior registration

or registered nurses. I wouldn't want to see too many

registered nurses often spending three years becoming

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REV. J. M. GALT: There are only a

number of medical school librarians who are registered

librarians.

REV. JAMES M. GALT: Thank you very much.

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and you were very patient to accept our invitation to



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TORONTO, ONTARIO

# ROYAL COMMISSION ON THE STATUS OF WOMEN

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4 come out of time. For that we are very grateful. We  
5 are trying to foresee the end of our hearings in Toronto  
6 and this is part of the program. We are obliged to you  
7 for it and for bringing this before us. The ramifications,  
8 as I say of health services are really quite extensive.  
9 I think the only ones we haven't heard from and for  
10 myself I would like to give them a course, and that is  
11 the telephone operators. I think the reputation of the  
12 hospital often stands or falls on just the way the  
13 telephone is answered. Thank you very much.

14 We will adjourn until 9:30 Monday  
15 morning.

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---Adjournment.





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are trying to forecast the end of our hearings in Toronto  
and this is part of the program. We are obliged to you  
for it and for bringing this before us. The ramifications  
as I say of health services are really quite extensive.  
I think the only ones we haven't heard from and for  
myself, I would like to give it a course, and that is  
the technical operation. I think the restoration of the  
hospital often stands on little or just the way the  
telephone is answered. Thank you very much.  
We will be back until 5:30 Monday

Thank you

# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

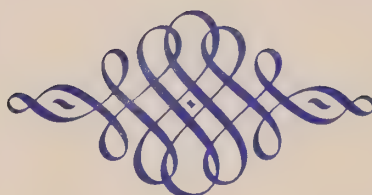
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ROYAL COLLEGE OF DENTAL SURGEONS  
OF ONTARIO AND ONTARIO DENTAL  
ASSOCIATION

DR. P. L. LARSON

HEALTH LEAGUE OF CANADA

DR. K. L. R. WIGHTMAN &  
DR. R. FARQUHARSON

OF CANADA

CANADIAN PLUMBING & MECHANICAL



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VOLUME NO 61

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 28th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O.J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE



Proceedings of the hearings  
held in Toronto, Ontario,  
in the 18th day of May, 1912.

COMMISSION MEMBERS:

Chief Justice HENRY J. HALL -- Chairman

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

PROF. C. L. FIERSTON

COMMISSION SECRETARY:

MEDICAL CONSULTANTS:

DR. PIERRE J. J. J.

COMMISSION REPORT:

COMMISSION OF ENQUIRY:



---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning is a joint submission of the Royal College of Dental Surgeons of Ontario and The Ontario Dental Association. It will be exhibit number 325, and Dr. Leckie will introduce his group.

---EXHIBIT NO. 325: Joint submission of The Royal College of Dental Surgeons of Ontario and The Ontario Dental Association.

SUBMISSION OF  
THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO  
AND  
THE ONTARIO DENTAL ASSOCIATION

APPEARANCES: Dr. A.H. Leckie  
Dr. E. A. White  
Dr. W.J. Dunn  
Dr. R.G. Ellis  
Dr. G. Nikiforuk

DR. LECKIE: Mr. Chairman and Members of the Royal Commission on Health Services: I would like to express the appreciation of the Royal College of Dental Surgeons of Ontario for the privilege of presenting a brief before you this morning.

I would like to introduce Dean R.G. Ellis, Dean of the Faculty of Dentistry of the University of Toronto; Dr. Wesley J. Dunn, Registrar-Secretary of the Royal College of Dental Surgeons of Ontario, who will present our brief; Dr. Gordon Nikiforuk, Head of the







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4 Department of Research, Faculty of Dentistry, University  
5 of Toronto; and Dr. E.A. White, the President of the  
6 Ontario Dental Association.

7 I would ask permission at this time  
8 that Dr. White be allowed to address the Commission  
9 very briefly.

10 DR. WHITE: Mr. Chairman, and Members  
11 of the Royal Commission on Health: The Board of  
12 Governors of the Ontario Dental Association deem it a  
13 privilege to be associated with the Royal College of  
14 Dental Surgeons in presenting this brief, and we hope  
15 we may be of some help to you in arriving at your  
16 findings.

17 DR. DUNN: Our President has graciously  
18 given me the opportunity of presenting this brief. If  
19 I might have the privilege of making one or two very  
20 brief comments before reading our recommendations. You  
21 will note I believe that our brief is not voluminous.  
22 I will admit to you quite frankly that most of the  
23 recommendations are based upon the factual material  
24 already having been presented to the Commission by the  
25 Canadian Dental Association. I would like to think that  
26 we made some contribution to that brief in the form of  
27 provision of material, and it seems unduly repetitive  
28 to include much of that material again. Also, you will  
29 have had the opportunity of reviewing the presentation  
30 from the Faculty of Dentistry of the University of  
Toronto, and again we have attempted not to be repetitive  
in the areas in which the Faculty is concerned. Also,  
sir, I think that this presentation is based upon, or at



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I would like to mention at this time that Dr. White is allowed to name the Commission very briefly.

Dr. White: Mr. Chairman, and Members

of the Royal Commission on Health: The Board of Governors of the Ontario Dental Association has it a privilege to be associated with the Royal College of Dental Surgeons in presenting this brief, and we hope we may be of some help to you in arriving at your

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given us the opportunity of presenting this brief. I might have the privilege of making one or two very brief comments before reading our recommendations. You will note I believe that our brief is not voluminous. I will admit to you quite frankly that most of the recommendations are based upon the factual material already having been presented to the Commission by the Canadian Dental Association. I would like to think that we make some contribution to that brief in the form of provision of material, and it seems entirely repetitive to include much of that material again. Also, you will have had the opportunity of reviewing the recommendations from the Faculty of Dentistry of the University of Toronto, and again we have attempted not to be repetitive in the areas in which the Faculty is concerned. Also, sir, I think that this presentation is based upon, on



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3 least the characterists of dental and oral diseases  
4 have been quite prevalent in our minds as we have  
5 developed much of this material, and I think we must  
6 not allow ourselves to fall into the entrapment of  
7 not differentiating between many of the factors which  
8 have a pertinence to the care and treatment of dental  
9 and oral diseases as opposed to those generally  
10 recognizable in the medical field.

11 We believe there are at least eight  
12 characteristics which have a pertinence, and it is on  
13 some of these that these recommendations are based:

- 14 (1) their multiple and cumulative aetiology
- 15 (2) insidious and asymptomatic onset and their  
16 persistent destructive progression in the  
17 absence of prompt treatment
- 18 (3) their high attack rates, beginning early in  
19 life
- 20 (4) extremely wide prevalence
- 21 (5) they are not curable in the ordinary sense  
22 of this term as applied to disease
- 23 (6) their treatment entails employment of bio-  
24 mechanical procedures which are time-  
25 consuming, hence relatively costly
- 26 (7) treatment needs tend to be recurrent
- 27 (8) until very recently no proven public health  
28 procedures were available for community-wide  
29 prevention of dental caries, the control of  
30 which is in many respects basic to the over-  
all problem of oral health





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have been quite prevalent in our minds as we have developed much of this material, and I think we must not allow ourselves to fall into the trap of not differentiating between any of the factors which have a pertinence to the care and treatment of dental and oral diseases as opposed to those diseases recognizable in the medical field.

We believe there are at least eight characteristics which have a pertinence, and it is on some of these that these recommendations are based:

- (1) Their multiple and cumulative character
- (2) Their insidious and asymptomatic onset and their subsequent destructive progression in the absence of prompt treatment
- (3) Their high attack rates, beginning early in life
- (4) Extremely wide prevalence
- (5) They are not curable in the ordinary sense of this term as applied to diseases
- (6) Their treatment entails expenditure of money
- (7) Mechanical procedures which are time-consuming, hence relatively costly
- (8) Treatment must tend to be permanent
- (9) Until very recently no known public health procedures were available for community-wide prevention of dental diseases, the control of which is in many respects basic to the overall control of oral health.



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4 The recommendations contained in our  
5 brief are twenty-six in number. We have tried to be  
6 reasonably brief in their exposition, with the expanded  
7 supporting statements toward the end of the brief.  
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3 R1. A NEW DENTAL SCHOOL FOR ONTARIO

4 It is recommended that a new dental  
5 school to accommodate sixty students per class and  
6 twenty-five dental hygiene students in each of the two  
7 years of a dental hygiene program be established in  
8 Ontario, immediately. Funds approximating \$4,000,000  
9 will be required and should be provided on an equal  
10 basis by the provincial and federal governments.

11 R2. DENTAL TEACHERS AND RESEARCH PERSONNEL

12 It is recommended that federal grants  
13 to universities be increased in order that faculties of  
14 dentistry may improve the ratio of full-time teaching  
15 staff to part-time staff. Generous fellowships are  
16 required to encourage carefully selected candidates  
17 who have demonstrated aptitude for full-time university  
18 careers in teaching and research. The Ontario require-  
19 ments in this respect would approximate \$75,000 per year.  
20 The fact that provincial university dental schools do  
21 make significant manpower contributions to provinces other  
22 than those in which they themselves are located suggests  
23 that the major responsibility for providing grants  
24 resides with the federal government.

25 R3. DENTAL CLINIC-FACULTY OF DENTISTRY

26 It is recommended that the University  
27 of Toronto which maintains the Faculty of Dentistry and  
28 any other university in the province which subsequently  
29 creates a dental school should receive a grant from  
30 public funds partially to offset the significant costs



41. A NEW UNIT OF STUDY

It is recommended that a new mental

school to research the given factors per class and

two-to-five mental hygiene students in each of the two

years of a mental hygiene program be established in

Ontario, respectively. Funds approximately \$2,000,000

will be required and should be provided on an equal

basis by the provincial and federal governments.

42. MENTAL TRAINING AND RESEARCH PROGRAM

It is recommended that a mental hygiene

to be established is increased in order that facilities of

dentistry now improve the ratio of full-time residents

staff to part-time staff. General facilities are

needed to encourage carefully selected residents

who have demonstrated aptitude for full-time residency

courses in teaching and research. The Ontario program

needs in this respect would approximate \$75,000 per year.

The fact that provincial universities do not provide

adequate facilities for research is a serious matter which

has those in which they themselves are interested.

At the same time, it is recommended that

cooperation with the federal government

43. MENTAL CLINICAL RESEARCH ON RESEARCH

It is recommended that a new unit

to conduct research in the field of clinical and

and other research in the field of mental hygiene

be established in a mental hospital during a period of

two to five years to effect the same.



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4 of operating an extensive out-patients' clinic. An  
5 annual grant based upon \$1000 for each student in the  
6 Faculty of Dentistry provided equally by the municipality  
7 in which the clinic is situated and by the Government  
8 of Ontario would materially assist in maintaining these  
9 clinical facilities.

10 R4. SPECIALISTS

11 It is recommended that when amounts of  
12 federal grants to universities are being determined  
13 consideration be given to the needs of dental schools to  
14 establish, maintain, and, where necessary, augment  
15 graduate educational programs to provide the academic  
16 qualifications necessary for graduate students proceeding  
17 to specialization.

18 R5. EXPENSES OF POST-GRADUATE COURSES

19 It is recommended that federal income  
20 tax regulations be amended to permit tax relief on authorized  
21 expenditures made by dentists who attend post-graduate  
22 training or refresher courses under the auspices of  
23 universities or recognized dental associations.

24 R6. RECRUITMENT

25 It is recommended that the Royal  
26 Commission on Health Services act on the request of the  
27 Canadian Dental Association to undertake a detailed,  
28 thorough study of recruitment to the health professions.

29 R7. STUDENTS FROM RURAL AREAS

30 It is recommended that the Government  
of Ontario through a program of subsidization encourage





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4. SPECIALISTS

It is recommended that when amounts of  
Federal grants to universities are being determined  
consideration be given to the needs of dental schools to  
attract, retain, and, where necessary, attract  
additional educational resources to provide the additional  
qualifications necessary for graduate students pursuing

5. FINANCIAL SUPPORT AND COUNSEL

It is recommended that Federal  
tax provisions be amended to permit tax relief on research  
expenditures made by dentists who attend postgraduate  
training or refresher courses under the auspices of  
universities or specialized dental associations.

6. RESEARCH

It is recommended that the Federal  
Commission on Health Services and on the Manpower of the  
Dental and Dental Assistant to Health Care be reauthorized,  
and that the Commission be directed to report to the House of  
Representatives and the Senate on or before the end of the  
first session of the 94th Congress.

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4 students from rural areas to seek admission to a Faculty  
5 of Dentistry and subsequent to graduation return to a  
6 rural area to practise. \$30,000 per year would provide  
7 subsidization for ten students in each of the first  
8 three years in dental school.

9 R8. UNIVERSITY FEES AND EXPENSES

10 It is recommended that, as university  
11 fees present an almost insurmountable barrier to many  
12 students who desire dentistry as a career, the federal  
13 government should increase its annual grants to permit  
14 universities to effect a significant reduction in  
15 academic fees.

16 R9. STUDENT FINANCIAL AID

17 It is recommended that the availability  
18 of bursaries and loan funds be increased to permit  
19 promising students from low income families to seek  
20 dentistry as a career. Dominion-Provincial Type  
21 Bursaries should be greatly increased.

22 R10. DENTAL RESEARCH

23 It is recommended that greatly augmented  
24 funds for training research personnel and for support  
25 of research projects be made available. As the products  
26 of research recognize no provincial boundaries an  
27 estimate of national need only can be given. It is  
28 estimated that by 1975 in Canada the financial support  
29 necessary for dental research will approximate \$3,000,000  
30 per year.

It is recommended that liaison  
between granting agencies and the Canadian Dental



Students from rural areas are advised to a Faculty of Dentistry and assistance to graduation year on to a rural area to practice. \$3,000 per year would provide subsidization for ten students in each of the five classes years in dental school.

#### 46. UNIVERSITY OF TORONTO

It is recommended that, as university fees present an almost insurmountable barrier to many students who desire dentistry as a career, the federal government should increase its annual grants to permit universities to effect a significant reduction in tuition fees.

#### 47. UNIVERSITY OF MANITOBA

It is recommended that the availability of bursaries and loan funds be increased to permit promising students from low income families to seek university education. Research should be greatly increased.

It is recommended that specific grants be made for training research personnel and for support of research projects be made available. As the proportion of research requested no provincial government as an estimate of national need may not be known. It is estimated that by 1975 in Canada the minimum amount necessary for dental research will be approximately \$1,000,000 per year.

It is recommended that a link be established between training research and the dental profession.





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Association's Council on Research be maintained and, if necessary, strengthened.

R11. FLUORIDATION

It is recommended that the Ontario Legislature be encouraged to amend the Fluoridation Act (R.S.O. 1961, C.30) to make mandatory the fluoridation of communal water supplies.

It is further recommended that communities which provide a fluoridated water supply qualify for financial assistance from federal and provincial sources. All three levels of government could share equally in the cost. It is estimated that the total annual cost of communal water fluoridation in Ontario would approximate \$400,000.

R12. DENTAL HEALTH EDUCATIONAL PROGRAMS

Because the control of dental diseases is essentially a matter of personal interest and responsibility there is a need to augment programs of dental health education. Such programs should be conducted within health units or regions and should be directed by dentists qualified in dental public health.

The programs should be focused upon the needs of pre-school and young children. Regular examinations and referral to private dentists through notification cards are required. Children should be taught good dietary habits consistent with Canada's Food Guide. Children should be taught correct and timely oral hygiene procedures. Parents should be given dental health instruction at pre-natal and child health clinics.





Grants from federal, provincial, and local sources should be provided to support such programs. It is estimated that a comprehensive program of dental health education in Ontario would entail an annual expenditure approximating \$1,000,000.

#### R13. SALARIES OF PUBLIC HEALTH DENTISTS

It is recommended that as the public health trained dentist is vital to a community or regional dental health program both in respect to its establishment and continuing successful operation, provincial and local health departments and other health agencies should effect salary schedules for dental health officers at least comparable to average incomes enjoyed by dentists in private practice.

#### R14. NATIONAL DENTAL HEALTH INDEX

The Ontario dental profession supports the Canadian Dental Association in its recommendation that the federal government should establish machinery to maintain through annual compilation of dental health data the dental health index initiated by the Association.

#### R15. DEMANDS FOR DENTAL SERVICES

As the determination of the demands (as opposed to needs) for dental service is, at best, a highly conjectural estimate it is recommended that the Royal Commission on Health Services in co-operation with the Canadian Dental Association undertake a study of the factors which influence demands for dental care.







R16. EXTENSION OF AUXILIARY SERVICES

It is recommended that dental schools conduct pilot studies and operational research to determine the most effective and productive methods of utilizing the services of auxiliary personnel in both private practice and public health programs. As the efforts of the various Canadian dental schools should be co-ordinated in this study a national committee composed of members of all universities with dental schools should be established. A federal grant approximating \$50,000 should be made available to initiate the appropriate clinical research projects.

R17. DENTAL HYGIENISTS

It is recommended that while the Faculty of Dentistry of the University of Toronto does possess an excellent dental hygiene program, other Canadian dental schools not at present providing courses in dental hygiene should be encouraged to establish them thus augmenting the supply of these very valuable auxiliaries.

R18. TRAINING DENTAL TECHNICIANS

It is recommended that the clinical facilities of university dental schools be utilized in the training of dental technicians. The program should be developed in Ontario as a joint project of the Royal College of Dental Surgeons and the Governing Board of Dental Technicians with the co-operation of the Faculty of Dentistry of the University of Toronto. Once the program of training for aspiring dental technicians has



412. LITERATURE ON DENTAL EDUCATION

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co-ordinated in this study a national committee composed

of members of all universities with dental schools

should be established. A federal grant approval time

\$25,000 should be made available to initiate the

appropriate clinical research program.

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413. THE DENTAL TECHNICIAN

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of Dentistry of the University of Toronto. When the

program of training for dental technicians is





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4 been established then present technicians could reinforce  
5 their own experience through planned training courses  
6 arranged on a half day per week basis over a determined  
7 span of time, or courses lasting from two or three days  
8 to, perhaps, a week or two in duration. The federal  
9 provincial partnership in the field of financial aid  
10 of vocational training could be extended to facilities  
11 for training dental technicians.

#### 12 R19. TRAINING DENTAL ASSISTANTS

13 It is recommended that training courses  
14 for dental assistants be established in Ontario in the  
15 Science, Technology and Trades branch of the secondary  
16 education program and in vocational schools. In addition  
17 to subjects indigenous to dental nursing or dental assisting  
18 a general educational experience is desirable coupled  
19 with book-keeping, typing and general secretarial duties.

#### 20 R20. TRAINING DENTAL STUDENTS IN THE USE OF ASSISTANTS

21 It is recommended that the Faculty  
22 of Dentistry of the University of Toronto be provided  
23 with funds to engage a sufficient number of well trained  
24 dental assistants to institute a program designed to  
25 teach dental students how to utilize the services of  
26 dental assistants most efficiently and effectively.

27 This would make possible the provision of more dental  
28 service to more people.

#### 29 R21. DENTAL SERVICES IN HOSPITALS

30 Under the authority inherent in Section  
31 1(p) of the Public Hospitals Act (R.S.O. 1960, C. 322),  
32 it is strongly recommended that dental departments should



been established that present technicians could reinforce their own experience through a formal training course arranged on a half day or week basis over a determined span of time, or courses lasting from two or three days to, perhaps, a week or two in duration. The federal provincial partnership in the field of hospital and of vocational training could be extended to facilities for training dental technicians.

It is recommended that training courses for dental assistants be established in Ontario in the sciences, technology and trades branch of the secondary education program and in vocational schools. In addition to subjects undergoing dental nursing or dental radiography a general educational experience is desirable coupled with book-keeping, typing and general secretarial duties.

250. TRAINING DENTAL STUDENTS IN THE USE OF X-RAYS  
It is recommended that the Faculty of Dentistry of the University of Toronto be provided with funds to equate a sufficient number of well trained dental assistants to instruct a program designed to train dental students how to utilize the x-ray machine. Dental assistants must efficiently and effectively. This will make possible the provision of more dental services to the public.

Under the authority inherent in Section 100 of the Health Services Act (R.S.O. 1980, c. 125) it is strongly recommended that dental assistants should



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4 be established in all public general hospitals in  
5 locations where dental personnel are available to provide  
6 both in-patient and out-patient services. Dentists duly  
7 appointed to the professional staffs of such hospitals  
8 should be enabled to render their professional services  
9 within a regulatory framework which gives full cognizance  
10 to their education, training, experience, and licensure.  
11 Dentists appointed to hospital staffs should possess  
12 the right to admit patients to hospitals and arrange  
13 for the necessary medical assessment of the patient by a  
14 member of the medical staff. The admission of patients  
15 for dental services by a member of the dental staff should  
16 be on the same priority basis as admissions for other  
17 generally-elective treatment services.

## 18 R22. OUT-PATIENT DENTAL SERVICES

19 It is recommended that out-patient  
20 dental clinics be established in public general hospitals  
21 to assist in meeting the dental treatment needs of  
22 marginal income groups. Dentists who have been accorded  
23 hospital staff privileges could provide service on a  
24 rotational basis and charges made to patients should be  
25 comparable to those assessed for other out-patient  
26 services. Facilities, auxiliary personnel, and equipment  
27 should be adequate to enable the participating dentists  
28 to render the maximum of high quality dental care.  
29 Should the Ontario Hospital Services Commission provide  
30 financial support for at least partial maintenance of  
out-patient services the dental department should receive  
its proportional share of such financial support for its  
out-patient dental services.





be established in all public general hospitals in locations where dental personnel are available to provide both in-patient and out-patient services. Dentists duly appointed to the professional staffs of such hospitals should be enabled to render their professional services within a regulatory framework which gives full recognition to their education, training, experience, and licensure. Dentists appointed to hospital staffs should possess the right to admit patients to hospitals and arrange for the necessary medical assessment of the patient by a member of the medical staff. The admission of patients for dental services by a member of the dental staff should be on the same priority basis as admissions for other non-surgical-dental treatment services.

It is recommended that out-patient dental clinics be established in public general hospitals to assist in meeting the dental treatment needs of low-income groups. Dentists who have been appointed to hospital staffs and who could provide services on a rotational basis and charges made to patients should be comparable to those assessed for other out-patient services. Facilities, auxiliary personnel, and equipment should be adequate to enable the participating dentists to render the maximum of high quality dental care. Should the Ontario Hospital Services Commission provide financial support for at least partial maintenance of out-patient services the dental department should receive its proportional share of such financial support for its



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R23. CLEFT PALATE CENTRES

It is recommended that in addition to the Cleft Lip and Cleft Palate Research and Treatment Centre at the Hospital for Sick Children, Toronto other such centres be established in childrens' hospitals and in general hospitals where adequate dental, paediatric, and associated services are available. Because much is yet to be learned about the potentially crippling problems created by cleft lip and cleft palate, research programs should be a concomitant of any treatment services provided.

R24. PUBLIC ASSISTANCE TREATMENT PROGRAMS

It is recommended that the Ontario Dental Welfare Plan as at present contracted between the Department of Public Welfare and The Royal College of Dental Surgeons be expanded to include other beneficiaries of the Department. There should be a gradual assimilation of all persons now receiving medical services through the Ontario Medical Welfare Plan. The estimated annual eventual cost of a program to provide basic dental care to the beneficiaries of the Department of Public Welfare is \$1,800,000. The continuation of the present pattern of the Department making a monthly per capita grant to the R.C.D.S. and the R.C.D.S. assuming responsibility for the administration of the plan should be perpetuated.

R25. PLACEMENT OF DENTISTS IN RURAL AREAS

It is recommended that rural communities, in order to encourage dentists to practise in them, should



233. CLEFT PALATE SERVICE

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234. PUBLIC ASSISTANCE TREATMENT PROGRAM

Dental Welfare Plan as at present contracted between the Department of Public Welfare and The Royal College of Dental Surgeons be expanded to include other beneficiaries of the Department. There should be a gradual assimilation of all persons now receiving relief of services through the Ontario Medical Welfare Plan. The estimated annual eventual cost of a program to provide basic dental care to the beneficiaries of the Department of Public Welfare is \$1,800,000. The continuation of the present pattern of the Department making a monthly per capita grant to the P.C.D.S. and the S.O.D.S. assuming responsibility for the administration of the plan should be perpetuated.

235. PLACEMENT OF CHILDREN IN LOCAL ADOPTIVE

It is recommended that in communities in order to encourage dentists to provide in them, should





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3 arrange for establishing and equipping a dental office  
4 commensurate with contemporary standards, should provide  
5 a guarantee of a minimum income for dental services to  
6 the children, and should make provision for the treatment  
7 of adult patients on a fee for services basis. The  
8 Dental Division of the Department of Health of Ontario  
9 in co-operation with provincial dental authorities,  
10 could give consideration to applications from municipi-  
11 palities seeking dentists. Care would have to be  
12 exercised in determining if the community could support  
13 a resident dentist and in minimizing an overlapping of  
14 dental service areas. The province should share equally  
15 with the municipality the costs involved.

16 R26. DENTAL SERVICE IN REMOTE AREAS

17 It is recommended that the Provincial  
18 Department of Health augment its present provision for  
19 travelling dentists to care for the needs of residents  
20 in areas where the population is too scattered to  
21 warrant a resident dentist. Railway coaches and trailers  
22 appropriately equipped and automobiles with trans-  
23 portable dental equipment could be employed. These  
24 dentists would be salaried employees of the Ontario  
25 Department of Health and would provide dental services  
26 for the children. The treatment of adults could be  
27 permitted after regular office hours on a fee for service  
28 basis. This program should be eligible for at least  
29 partial support from national health grants.  
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arrange for salaried and assigning a dental officer  
 co-operate with other temporary standards, should provide  
 a guarantee of a minimum in the dental services to  
 the children, and should make provision for the treatment  
 of adult patients on a fee-for-service basis. The  
 Dental Division of the Department of Health of Ontario  
 in co-operation with provincial dental authorities,  
 could give consideration to applications from municipal  
 dentists seeking dentists. There would have to be  
 a decision in determining if the community could support  
 a resident dentist and in determining an overlapping or  
 dental service areas. The province should share equally  
 with the municipality the costs involved.

### RECOMMENDATIONS IN SHORT HAND

It is recommended that the following  
 Department of Health implement its present provision for  
 travelling dentists to care for the needs of residents  
 in areas where the population is too scattered to  
 warrant a resident dentist. Railway coaches and trailers  
 equipped with dental equipment and automobiles with dental  
 equipment should be employed. These  
 dentists would be salaried employees of the province  
 and would be available for dental service  
 on the call. The treatment of adults could be  
 provided after regular office hours on a fee-for-service  
 basis. This program should be aimed at the  
 dental service from national health service.



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THE CHAIRMAN: Thank you, Dr. Dunn.

Commissioner Strachan, would you begin the discussion this morning?

COMMISSIONER STRACHAN: Thank you,

Mr. Chairman. If I may be permitted to make a few observations to start with. I would like to point out, first of all, that this is the only brief being presented by dentistry in Ontario. It is being presented by two bodies, the R.C.D.S., which is the legal body of the province, and the voluntary body, the Ontario Dental Association. So even though they represent the same individuals in the province, they are, nevertheless, two different groups who have co-operated in the presentation of this brief.

And may I also observe that I think we should recognize the fact that these groups, this presentation, represent over 40% of the dentists in Canada.

It is a pleasure to have these gentlemen before us this morning, and may I say that I have held these gentlemen in the highest personal and professional respect for many years, and I am sure they have much to offer this Commission.

I propose to ask a few questions which well might have been asked of each and every dental group before this Commission, but to prevent repetitious questioning which may have been very boring to my fellow commissioners I have left them for the last group.

There will be questions put to you for straightforward statements of fact which may be reviewed by this







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Commission or any other interested individual or group in the future.

In this case. Some of these questions may, of necessity, be technical, but the terminology will be as simple as possible.

Many dentists. I think we might as well commence with the one subject which would be expected to be mentioned in this case, with reference to fluoridation. It seems there have been press reports to the effect that the Royal College of Dental Surgeons have not endorsed fluoridation or, more particularly, have not supported or endorsed the report of the Morden Commission on fluoridation.

General Government. Would you like to comment on that, Dr. Dunn?

Area 100,000 of DR. DUNN: Yes, I would, Dr. Strachan. Please forgive me, because I am not being facetious when I say this: it is a comment something akin to saying: "I saw your Minister last Saturday and he wasn't drunk." That statement might be valid, but the conclusions that one might draw from it might be particularly invalid.

We believe it is. It is true that our Board did not endorse the Morden Commission Report simply because we did not establish the Commission; it was set up by the Ontario Government. We did not feel it incumbent upon ourselves to adopt or endorse a particular report. However, whatever the comments and conclusions which were made, you will notice in this brief we have indicated that both organizations, the R.C.D.S. and the O.D.A., endorse most strongly the conclusions of the Morden



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Some of these questions may, of neces-

sity, be technical, but the terminology will be as  
simple as possible.

I think we might as well commence with  
the one subject which would be expected to be mentioned  
in this case, with reference to fluoridation. It seems  
there have been press reports to the effect that the  
Royal College of Dental Surgeons have not endorsed  
fluoridation or, more particularly, have not supported  
or endorsed the report of the Morden Commission on

Would you like to comment on that, Mr.

Grant?

MR. DUNN: Yes, I would, Dr. Stroschan.

Please forgive me, because I am not really facetious when  
I say this: it is a comment something akin to saying:  
"I saw your Minister last Saturday and he wasn't drunk."  
That statement might be valid, but the conclusion that  
one might draw from it might be particularly invalid.  
It is true that our Board did not

endorse the Morden Commission Report simply because we  
did not establish the Commission; it was set up by the  
Ontario Government. We did not feel it incumbent upon  
ourselves to adapt or endorse a particular report.  
However, whatever the comments and conclusions which  
were made, you will notice in this brief we have indicated  
that both organizations, the P.C.I.S. and the O.C.A.,  
endorse most strongly the conclusions of the Morden





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Commission Report, and, as a matter of fact, we have included the conclusions of the Morden Committee Report in this brief.

COMMISSIONER STRACHAN: In your Recommendation No. 12, regarding public health training, how many dentists in Ontario have the public dental health training?

DR. DUNN: I believe at the last count there were 18 men qualified with their diplomas in public health. This includes those who have very recently concluded their training at university and all of them are not directly engaged in dental services in Ontario; two of them, for instance, are with the Federal Government.

COMMISSIONER STRACHAN: Have you any idea how many could be used in the province if they were trained?

DR. DUNN: We believe certainly double that number could be effectively employed right now. There are many health units in regional areas not now enjoying the services of a public health trained dentist. We believe it would be a real impetus if all health units had public dental health trained people to give leadership, both to the district in which they are located and, of course, to the public.

COMMISSIONER STRACHAN: You have stated that a public health dentist is vital to the key to the public health problem. What do they do in their normal line of business?

DR. DUNN: The public health dentist -



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...ion Report, and, as a matter of fact, we have included the conclusions of the Jordan Committee Report in this brief.

COMMISSIONER STANLEY: In your Recommendation

...ion No. 12, regarding public health training, how many dentists in Ontario have the public health training?

DR. DUNN: I believe at the last count there were 16 men qualified with their diploma in public health. This includes those who have very recently completed their training at university and all of them are not directly engaged in dental service in Ontario; two of them, for instance, are with the

COMMISSIONER STANLEY: Have you any

idea how many could be used in the province if only

DR. DUNN: We believe certainly, people that number could be effectively employed right now. There are many health units in regional areas not now enjoying the services of a public health trained dentist. We believe it would be a real improvement if all health units had public health trained people to give leadership, both to the district in which they are located and, of course, to the public.

COMMISSIONER STANLEY: You have stated

that a public health dentist is vital to the way to solve public health problems. What is that in their normal line of business?

DR. DUNN: The public health dentist -



Dunn

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I don't know how I can answer this very quickly - the public health dentist, depending on what level he finds himself, has fairly broad duties. In a local unit, he is the one who would, of course, hire the staff, he would arrange for the necessary budgets, he would make all the applications for public health grants; he is the man who would be the liaison between the public health need in the community, the professional resources available and the health staff.

He would be required to make an assessment of the needs and resources of the community. It would be his responsibility to design programs to fit these needs and resources and to establish and perhaps operate them. He would attempt to establish the criteria for the measurement and assessment of the programs, and where the results have been unsuccessful, perhaps to study and improve the programs.

He would prepare the necessary news releases on the programs and would be required to prepare reports for the director of the health unit or for the Department of Health.

As far as the direction of dental health is concerned, he would be required to choose the methods to be employed, the various media he would wish to use and the timing of his program. I think he would have to prepare and secure the material to fit the community need; he would be responsible for fitting key communication people in the medium to be used.

He would arrange for the distribution of material to provide the greatest effectiveness and





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He would arrange for the dissemination of material to provide the greatest effectiveness and



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TORONTO, ONTARIO

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also to improve functioning, comprising of organization,  
communication people, arrange interviews, prepare reports,  
news releases and the like.

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also to improve the quality of the information  
communication process, arrange interviews, prepare reports  
news releases and the like.

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Also dental training for the staff in these dental health units is important. He would make such other arrangements, perhaps he would hold seminars with dentists on education and arrange for various dental associations for seminars to bring up the calibre of dental service to the public. As far as the program is concerned he would have a lot to say on fluoridation, he would be concerned with dietary control; in that respect there are now several tests which can be employed in public health which give some indication of the caries or tooth decay activity going on in the mouths of children. Pre-school dental service we think is very important because, as you know, in this enlightened community of Metropolitan Toronto we find even our two-year old children are already involved in a tooth decay process. Pre-school activities are very important. Within the schools the programs they follow are well-known, an education program both direct and indirect through the training of teachers, screening examinations, referral to private dentists, dental examinations which are designed to provide statistical and referral material for and follow-up cases where the thing has been gross and deal particularly with handicapped children. Many of these people do work and, incidentally, dental service given to indigents. They can play rather a key role in the recruitment of potential services to industry, because they see so many of the people in Canada. I refer in this recruitment role not only to dentists but auxiliary services.

COMMISSIONER STRACHAN: Are these dental



in these dental health units is important, he would  
make such other arrangements, and also he would hold  
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dental associations for dentists to bring up the subject  
of dental service to the public, as far as the program  
is concerned he would have a lot to say on this subject,  
he would be concerned with dietary control, that  
respect there are now several tests which can be employed  
in public health which give some indication of the degree  
of dental decay activity, and on the matter of dental  
pre-school dental services we think is very important  
to know, as you know, in this enlightened community of  
Toronto we find even in the early years of  
children are already involved in a tooth decay program,  
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this respect it is not only the dentists and a similar  
services.



Dunn

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health programs proving effective?

DR. DUNN: We believe they are.

Perhaps the earliest program which we might make reference is the one of the Welland-Crowland Health Unit being about 1945. The profession had the sincere conviction that an educational program offered advantages which the traditional treatment programs did not. The profession managed to obtain the help of the Canadian Red Cross Society to sponsor a public health plan in the Welland-Crowland Health Unit and we are grateful to the Red Cross for that. We are grateful for the cooperation and the help of Dr. Leo Sturgeon. It is rather interesting to remember that with Dr. Honey's arrival in Welland the Welland-Crowland Health Unit was meeting the needs of approximately one child per day and within three months the average dentist in the community was now starting to care for between seven and eight children a day and because of the fact there were fourteen to sixteen dentists rendering treatment this was much more effective than the method of one dentist in a clinic attempting to give clinical service. Since that time there has been a gradual diminution, I believe, of the teeth decaying picture in that health unit. I believe, of course, this is partly attributable in Thorold to the fluoridation of communal water supplies, but we believe the program undertaken by Dr. Honey with the public and with the profession has been beneficial to that community. Most other health programs have not been existing for a sufficient period of time to bring us to make the type of observations we would like to do.



Health program provided assistance

for the earliest program which might have been  
as one of the Health-Growth program.

an educational program of health and growth which the  
traditional treatment programs did not. The profession  
was to obtain the aid of the Canadian Red Cross

Society to sponsor a public health plan in the Health-  
Growth program and as a result of the plan

for that. We are grateful for the cooperation of the  
help of Dr. Leo Thompson. It is rather interesting to  
remember that with the health plan in Health-Growth

Health-Growth Health plan was meeting the needs of  
approximately one child per day and with that the  
the average dentist in the community was not able to

to care for between seven and eight children a day, and  
because of the fact there were between six and ten  
continuing treatment and was much more efficient than the

method of one dentist in a clinic or hospital to care  
of the children and that time there was a health  
program, I believe, of the health plan.

to care in the health plan. I believe, of course, this  
to give a health plan in Health-Growth to the Health-Growth

commune water supplies, but we believe that a health plan  
to give the health plan with the health plan and with the health plan  
has been found to be that health plan, but of course, the health plan

to give the health plan to make the type of health plan as  
well as to give the health plan.



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COMMISSIONER STRACHAN: Thank you, Dr. Dunn. Your recommendation asks for dental services, what percentage of people in Ontario actually seek and receive dental services?

DR. DUNN: We believe the profession will provide dental treatment services to approximately 30% of our population in any one year. This does not mean to say that over a period of several years the percentage will not be greater, but in that 30% I include those who seek what we might call emergency services, extraction of a tooth which is giving them trouble. Extending to those who seek and obtain more or less complete service, certainly it is not more than one-third of our population ever seeking dental care in any one year. Of course, we believe certainly for the average patient anyway, that two visits a year to a dentist is a desirable thing to do.

COMMISSIONER STRACHAN: Is the demand higher for dental services than can be procured and if so, how much greater?

DR. DUNN: I think this is one of the concerns we have attempted to state here, that because it is so conjectural it is a very difficult question to ask. It has been my observation that when dental services have been made available people employ these services because the community may not have a dentist and I think we can conclude from that that these people do not want dental care. Certainly, especially in our more rural communities the demands of the public are not at this moment being made available. In many of our



Dr. Dunn, can you tell us in 1940 for dental services  
what percentage of people in Ontario actually seek and  
receive dental services?

Dr. Dunn: It is difficult for the profession  
to provide dental treatment services to a population  
of our population in any one year. This does not  
mean to say that over a period of several years the  
percentage will not be greater, but in 1940 I include  
those who seek what we might call emergency services,  
extractions of teeth which is a very high figure.  
Extending to those who seek and obtain more or less  
routine services, certainly it is not more than 50% of  
the population who are seeking dental care in any one  
year. Of course, we believe certainly for the next  
patient anyway, that two visits a year is a desirable  
a desirable thing to do.

COMMISSIONER OF HEALTH: I am interested  
in the fact that dental services then can be obtained and  
so, that is the present.  
Dr. Dunn: I think that is one of the  
concerns we have attempted to state here, that because it  
is so difficult to get a very efficient service to  
ask. It is a poor observation that when dental  
services have been made available people do not use them  
services because the community may not have a dentist and  
I think we can conclude from that that these people do  
not want dental care. Not only, especially in our  
more rural communities the demands of the people are not  
at this moment being met satisfactorily. In many of our





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large metropolitan areas the profession is unaware of any gross demand that it is incapable of meeting. Certainly in our smaller areas I think there is validity to the suggestion that we are incapable of providing individual dental treatment services.

COMMISSIONER McCUTCHEON: Coming to the metropolitan areas, you say you believe the profession can take care of the demand; now, is that still a demand related to about one-third of the population?

DR. DUNN: Here again we are not too sure that we can differentiate between the metropolitan municipality and the more rural area. Again, we are not convinced that the demand for dental care in our large areas such as the City of Toronto that this demand exceeds 40% of our population. We think, however, as you perhaps are aware, in Metropolitan Toronto the ratio of one dentist to every approximate 1,650 people but for many counties throughout the Province the ratio is one to 4,000 or even 5,000. In questioning a statistically acceptable supply of dentists in the Toronto area we are not really aware of an overwhelming demand that we cannot meet. It is perfectly true that if a patient wishes an appointment next Monday afternoon at two p.m. he may have difficulty obtaining it.

COMMISSIONER McCUTCHEON: How long would he have to wait?

DR. DUNN: Here again it will depend upon the length of time the individual has been in practice, the record he has in the community. With some dentists it may be several weeks before the patient can be



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large metropolitan areas the profession is unaware of any gross demand that it is incapable of meeting. Certainly in our smaller areas I think there is validity to the suggestion that we are incapable of providing individual dental treatment services.

COMMISSIONER MCCORMACK: Coming to the metropolitan areas, you say you believe the profession can take care of the demand; now, is that still a demand related to about one-third of the population?

DR. BURN: Here again we are not too sure that we can differentiate between the metropolitan municipality and the more rural areas. Again, we are not convinced that the demand for dental care in our large areas such as the City of Toronto that this demand exceeds 40% of our population. We think, however, as you perhaps are aware, in Metropolitan Toronto the ratio of one dentist to every approximately 1,650 people but for many countries throughout the Province the ratio is one to 4,000 or even 5,000. In metropolitan areas we are acceptable density of dentists in the Toronto area we are not really aware of an overwhelming demand that we cannot meet. It is generally true that if a patient wishes an appointment next day afternoon at two o'clock, he may have difficulty obtaining it.

COMMISSIONER MCCORMACK: Now, how would he have to wait?

DR. BURN: Here again it will depend upon the length of time the individual has been in practice. It may be several weeks before the patient can be



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conveniently seen. I could also say there are dentists in the Metropolitan Toronto area who could see patients this afternoon, it depends on the individual himself.

COMMISSIONER STRACHAN: What do you consider the most important initial steps to improve dental health in Ontario?

DR. DUNN: There are two initial steps we think very important. The first step is the institution of a provincial health program operated by public health trained dentists. We think if each major municipality, each health unit has such a thing, that they could do a great deal positively for dental health. Then, the second, of course is the fluoridation of the communal water supply; we cannot overlook this as perhaps the most effective and efficient method for at least the partial reduction of dental caries. It is a tragedy, I think, that over the last few months in some 17 municipalities they have expressed their views on this subject and 12 of them have rejected it and five have accepted it. We would suggest that the citizens or the future citizens of these communities will suffer thereby. These are the facts of life and, unfortunately, we cannot do anything about it except encourage people to adopt this as a sound, proven and accepted public health measure. In summary, I think dental health educational programs, fluoridation of the communal water supplies are the two major concerns we have at this moment.

COMMISSIONER STRACHAN: Now, I might refer to recommendation number 18, training of dental technicians who are recognized as a component of the







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dental group. Would you care to expand on this recommendation number 18?

DR. DUNN: This is of some concern to us that although dental technicians are registerable in Ontario, that is, they must meet certain criteria as established by the governing body of dental technicians, they must pass examinations, there is no course of training for them in other areas, health services such as radiological services, laboratory services and hospitals. The public general hospitals can frequently be employed as facilities for training technicians in these areas because of the dearth of dental services in hospitals generally it would not be propitious to employ public hospitals for the training of dental technicians. The clinical facilities we have which could be considered comparable to those provided by the public general hospitals are found in the Faculty of Dentistry at the University of Toronto. In this Province the University, I think quite rightly, has some concern about establishing or employing these facilities for the training of technical personnel. However, I do think that there is special circumstances here; it happens to be the only source for clinical training that we have which comes under some sort of disciplinary academic oversight and we would like to see these facilities employed for this purpose. We think something needs to be done in terms of training dental technicians.



...to explain on this occasion  
...number 1

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...because of the fact that dental services in hospitals  
...generally it would not be in position to employ a  
...technician for the training of dental technicians, the  
...clinical facilities we have which could be considered  
...in the case of those involved by the public health  
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...University of Toronto. In this Province the University  
...I think quite rightly, has some concern about dental  
...of education, these facilities for the training of technicians  
...however, I do think that there is a  
...from these people. It happens to be the only source for  
...training that we have within Ontario and some  
...and a great deal of research is being done and we are  
...to see that facilities developed for this purpose. We  
...think certainly need to be done in order of training  
...of dental technicians.





Dunn

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DR. DUNN: We think something needs to be done in terms of training dental technicians.

COMMISSIONER STRACHAN: Now, at this point, Dr. Dunn, I feel that we should refer to a relative subject. This Commission has had representations from denturist groups who feel there should be legislation permitting them to render some aspects of dental treatment directly to the public.

What are your views on this matter?

DR. DUNN: You made reference, sir, to - I don't know whether I caught it - to the denturist group?

COMMISSIONER STRACHAN: Yes, denturist group.

DR. DUNN: First of all, we do not believe that there is any group in Canada, whether they call themselves denturists or public denturists, or whatever they may be, competent to deal directly with the public in the area of dental service.

If I may expand on this a bit, sir, the principle by which our profession concerns itself in this area is that the dentist is the only person trained, through an educational and training experience, to have full responsibility for the dental care of the public. We believe that the dentist's responsibility extends to all aspects of his practice: the care and custody of his reception room, the business of his sterilization, laboratory functions, and the rest of it, does not mean that the dentist himself has to perform all these procedures; he must be responsible for them.



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to be done in terms of training dental technicians.  
COMMISSIONER STANLEY: Now, at this

point, Dr. Dunn, I feel that we should refer to a  
relative subject. This Commission has had representa-  
tions from dentists from a number of these schools be-  
cause of the situation permitting them to obtain some aspects of  
dental treatment directly to the public.

What are your views on this matter?

DR. DUNN: You have referred, sir, to -  
I don't know whether I ought to - to the technical  
groups

COMMISSIONER STANLEY: Yes, certainly  
groups.

DR. DUNN: First of all, we do not  
believe that there is any group in Canada, whether they  
call themselves dentists or public dentists, or  
whatever they may be, competent to deal directly with  
the public in the area of dental services.

If I say anyone on this side, sir,

the principle is that the protection comes as itself

in this case is that the dentist is the only person

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to have full responsibility for the dental care of the

public. We believe that the dentist's responsibility

extends to all aspects of his practice, the same and

consistency of his education, the history of

specialization, laboratory facilities, and the rest of it, sir,

not mean that the dentist is not responsible for the

of the dentist's responsibility for the



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We know of no group called denturists which has had an academic program sufficient to fit its profession to deal directly with the public.

We believe that the dental technicians now in existence in Canada provide a full and important service to the profession. They render their attention within the instructions of the profession on the basis of the prescriptions which are sent to these laboratories, and in this way the public is assured of the most highly trained person in dealing with dental requirements.

We do not believe that the licensing of untrained people will be beneficial to the public in any way whatsoever, and certainly we feel it will be most debilitating to a profession who has been attempting to provide health care service to the public.

COMMISSIONER STRACHAN: Thank you, Dr. Dunn.

THE CHAIRMAN: Can these people be trained so as to perform a useful function?

DR. DUNN: Mr. Chairman, we believe that there are technical procedures in parts, technical procedures which can be delegated to appropriately trained people under the responsible supervision of the profession.

THE CHAIRMAN: Well, what do you mean by that? Responsible supervision? Visual supervision?

DR. DUNN: To a degree. The way a hygienist, for example, provides her service in the mouth of a patient within the responsible supervision of a dentist. That does not mean, however, that every





is now a no group called dentists  
which has had an excellent reputation sufficient to fit its  
profession to deal directly with the public.  
We believe that the dental professions

within the instructions of the profession on the basis  
of the prescriptions which are sent to these laboratories  
and in this way the public is assured of the most highly  
trained person in dealing with dental requirements.  
We do not believe that the licensing

of a dental practice will be beneficial to the public in  
any way whatsoever, and certainly we feel it will be  
to provide dental care service to the public.

The question is: Can these people be  
trained so as to perform a useful function?  
The answer is: Certainly, we believe that

trained people under the responsible supervision of the  
profession.

Q: What, then, do you mean?

A: I mean to a group. The way a  
dentist, for example, provides his service in the  
form of a treatment within the responsible supervision  
of a dentist. That is not what, however, that group



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3 time a hygienist cares for the need of a patient, that  
4 the dentist must examine that patient to determine  
5 whether that has been competently performed. Any more  
6 than, for instance, I would have to check up on my  
7 secretary every time a letter or communication is typed  
8 because I would have confidence in her ability.

9 Just as I am responsible for what goes  
10 on that paper, I think the dentist must be responsible  
11 for the services which the patient is to receive. This,  
12 sir, is the principle on which we operate and we believe  
13 that there are technical procedures; what they are, we  
14 are not exactly sure at this moment. Perhaps Dean Ellis  
15 might wish to expand on this because commencing this  
16 Fall there will be an experimental program undertaken  
17 in our Faculty here to attempt to see what technical  
18 procedures hygienists, perhaps, could be trained to do.

19 THE CHAIRMAN: We are not talking about  
20 them. We are talking about the dentists now.

21 DR. DUNN: That is true. I mention  
22 hygienists because this is a group that we are now  
23 going to experiment with. The denturist is a group, at  
24 the moment, we do not recognize. I think this is a name  
25 that has been adopted.

26 THE CHAIRMAN: Whether you recognize  
27 them or not - I am not trying to provoke an argument -  
28 they exist and are recognized by the legislatures of some  
29 provinces as having some rights.

30 Now, if we accept the proposition that  
he is here, you say, and I am not challenging your  
right to say that he is not competent to do these things







Dunn

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that he is performing the best that he can do.

Now, there may be two solutions. One is to suppress him entirely. The other would be to elevate him. Is it possible to elevate the training or to elevate this individual by training so he would perform a function which, in the light of the great shortage of dentists, would appear to give some validity to his existence?

DR. DUNN: I don't think suppression, sir, would be our goal at all. We do believe that people can be trained to provide certain technical functions. I think my answer to your second question would be yes. I think he must have a course of study or training which will fit him for the role he has to discharge.

THE CHAIRMAN: I think that would be easy to accept. Having been so trained, does he necessarily have to act under the direct supervision of a dentist or may he not be an independent agent with the recognition that the dentist's responsibility for him does not extend to complete responsibility?

DR. DUNN: I think, sir, that if he is not responsible to a dentist, then we have, in effect, created a second class of dentists and I do not believe that this would be beneficial, in the long run, to the public.

Just as a radiological technician provides a most useful service to the medical profession, he is, in the final analysis, responsible to a physician for the service which he renders.



that he is performing the best that he can do.

Now, there may be two questions. One

is to appraise him objectively. The other would be to

elevate him. Is it possible to elevate the training

on to elevate this individual by training so he would

perform a function which, in the light of the great

shortage of dentists, would appear to give some validity

to his existence?

But, I don't think of this as a question.

It would be our goal at all. We do believe that

people can be trained to perform certain technical

functions. I think an answer to your second question

would be yes. I think he must have a course of study

on something which will fit him for the role he has to

and I think I think that would be

easy to accept. Having been so trained, does he neces-

sarily have to act under the direct supervision of a

dentist or may he not be an independent agent with the

responsibility that the dentist's responsibility for him

does not extend to complete responsibility?

But, I think, yes, that if he is

not responsible to a dentist, then he must, in effect,

operate a second class of dentists and I do not believe

that this would be beneficial, in the long run, to the

public.

Just as a medical profession

provides a useful service to the medical profession,

so is, in the dental analysis, responsible to a physician

in the sense that he answers



Dunn

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We believe the same principle can apply with equal validity to the dental environment but at the moment we do not have these people.

COMMISSIONER McCUTCHEON: In Ontario.

DR. DUNN: I know of no statute which refers to a denturist. We do know, in Alberta and in British Columbia, it makes reference first to dental technicians as a group and dental mechanics as a group.

THE CHAIRMAN: But they have called themselves denturists?

DR. DUNN: I think that is true.

THE CHAIRMAN: Getting into another field, the generic name they have got.

DR. DUNN: We have had that in another context I am aware of.

COMMISSIONER BALTZAN: What would the denturist actually do?

THE CHAIRMAN: Put it this way: what do they claim to do?

DR. DUNN: My understanding of what they claim to do is to provide denture service; usually complete or full denture service directly to the public.

THE CHAIRMAN: These are replacements, are they?

DR. DUNN: Yes. Denture service.

THE CHAIRMAN: I mean, it is not initial but replacement service?

DR. DUNN: I am unaware of that.

THE CHAIRMAN: Is there a difference? I can be wrong. I am only putting it to you by way of





...the same thing, and they  
with great velocity to the point of view, but at the  
moment we do not have a clear picture.

COMMISSIONER: I am not sure if it is  
DR. LINDSAY: I am not sure if it is  
reference to a document. It is known in America and in  
British Columbia, it makes reference to the fact  
technicians as a group and technical mechanics as a group.  
THE CHAIRMAN: But they have called

DR. LINDSAY: I am not sure if it is  
THE CHAIRMAN: I am not sure if it is  
it is, the present time, they have gone.

DR. LINDSAY: We have not yet in the  
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Dunn

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a question. They do not extract teeth? Start away with that.

DR. DUNN: That is true. We have not heard that they have extracted teeth, but they are dealing basically with an edentulous mouth or which eventually will become edentulous.

THE CHAIRMAN: They can't put the denture in until the teeth come out.

DR. DUNN: They can do the preliminary procedures preparatory to having those dentures fitted and the teeth have been removed.

THE CHAIRMAN: Well, the person goes to the dentist and has the teeth removed?

DR. DUNN: Yes.

THE CHAIRMAN: Or the doctor pulls it out by himself?

DR. DUNN: The teeth could be removed after the denture has been constructed. In fact, I would suggest that perhaps most of them are done that way today.

COMMISSIONER BALTZAN: I just wanted to know to what extent they function at the present time. It's in a mechanical sense?

DR. DUNN: Yes, that is correct.

COMMISSIONER BALTZAN: Could there be sort of a formalized program for such people? Formal training, so that they could get into the scheme of things? They work within their own field and then you would be responsible if they outstep their field?

DR. DUNN: Our faculties are going into







Dunn

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this in view of the fact that we hear so much about the shortages.

DEAN ELLIS: Mr. Chairman, I would say, in support of what Dr. Dunn has said, there is no question that you can train people to do things in a formal way, yes.

I think in our presentation a couple of weeks ago we referred to the fact that we would strongly recommend that there be no new type of auxiliary personnel introduced until such time as we have determined the greatest and most effective use that can be made of dental assistants and dental hygienists.

Now, there are certain phases of the work that the denturist claims to do today that I am sure a dental hygienist could be trained to do.

We have set up, as of next Fall, an experimental program in respect to the training of dental hygienists who are now formally recognized and trained by the university and we believe that perhaps some of these functions the dental hygienists can be trained to do. They are already established as a service, an ancillary service within the dental profession.

We believe this should be explored to the maximum before we get into a new group such as the denturists. I would also support the comment of Dr. Dunn about the two-level dentistry. This has happened in some of the countries in Europe and I can assure you that from information, from my study of these situations, they have regretted they have ever got into this.



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When I talk to Mr. Chipman, I would say,

in a report of what Dr. Dorn has done, there is a

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contingents. I would like to present the content of it.

from about the 4-level dentistry. This has happened.

in some of the countries in Europe and I am sure you

that from the United States, from the United States and

they have not used the same type of dentistry.



Ellis

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When you encourage two types of personnel who are independent of each other within this field, you get sub-standard dentistry which I do not think the Canadian people would want to accept. I think the Canadian people had and are used to a better type of dental service than the kind of thing you would get into with it.

There is no question you can train people to do things if you take time to provide the necessary instruction.

One other comment about the denturists as they presently exist: they are dealing with the soft tissues. They make the replacement which must be inserted on soft tissue. We know very well and we have lots of examples of the denturists being responsible for irritation that ultimately leads to a malignancy. This is not something that is uncommon. Oral malignancy; there is a fairly high percent of it.

The denturist, at present, is not trained to recognize the physiological principles that are operating in the mouth as they are in any other part of the body and just because this is something that fits on the tissue doesn't mean that it is removed from its influence on the physiological functions, and this is one of the things that has to be watched, I think, very carefully.

COMMISSIONER VAN WART: How do the denturists get their training?

DEAN ELLIS: By breaking dental regulations and Acts, I suppose. I think it was stated in one





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Ellis

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of the western provinces that if you had been breaking the law for 10 years, you can become, 'immediately become, a denturist.

COMMISSIONER VAN WART: I mean their mechanical training. Where do they learn it?

DEAN ELLIS: By indentureship with other people of the same category.

THE CHAIRMAN: Somebody started it.

DEAN ELLIS: There is no formal training.

THE CHAIRMAN: Some of them started in the employ of dentists?

DEAN ELLIS: As technicians, yes; by indentureships.

THE CHAIRMAN: Now they do the same work, they purport to do the same work whether they do it working for the dentist or independently? They may not do the same quality of work.

DEAN ELLIS: If they are working for the dentist, they are not working in the mouth, I would suggest.

THE CHAIRMAN: They are fabricating the business that goes in the mouth.

DEAN ELLIS: That is the technical aspect which we recognize as the right and field of the dental technician but he doesn't do work in the mouth. The dentist is actually working in the mouth.

THE CHAIRMAN: You say the harm comes when that is introduced to the person?

DEAN ELLIS: Yes.



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THE CHAIRMAN: You say the name of

work that is introduced to the patient?

DEAN ELLIS: Yes.





ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Ellis

11520

THE CHAIRMAN: From the improper fit.

DEAN ELLIS: The control on this in the dentist-technician relationship is on the dentist. He is responsible for the way in which the impression is taken, the way the denture is seated and adjusted to the mouth, which is the training of the dentist but the technician does the fabrication in the laboratory, yes.



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Dunn 11521

COMMISSIONER STRACHAN: In recommendation 21, you have referred to dental services in hospitals. What is the situation with regard to dental services in hospitals in Ontario?

DR. DUNN: Mr. Chairman and Dr. Strachan, I think that dental services of a degree are available in several large public general hospitals in Ontario. We don't believe, however, that in any institution have they yet come to the place where they are really providing the, or making the contribution that they could.

Dental services in hospitals have been of some concern to us because of what we have considered to be somewhat out-dated, almost archaic, legislation which surrounds dental service in hospitals. Until March of 1959, there was no legal authority for the provision of dental services in hospitals at all in this Province, although most of the hospitals had some services at that time. Since the passage of the amendment to The Public Hospitals Act of this Province, these services have been legalized, but the general regulations which are made pursuant to this statute have not yet been so amended that dental services can be provided in the way in which we feel that they should be.

We have made certain observations to the Ontario Hospital Services Commission, not without, I think, a degree of sympathy on their part. The mere fact that they now will provide a coverage for many dental services in hospitals is indicative to us that the Commission, at least partially, are sympathetic to this.

I think that some of these regulatory





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Dunn 11522

provisions with which we are having difficulty will soon be straightened out.

COMMISSIONER STRACHAN: The next recommendation, out-patient dental services, you have referred to marginal income groups. How do people who cannot pay obtain dental services?

DR. DUNN: I believe that in the main in this Province people who cannot pay for dental services must obtain them gratuitously, if you like, from members of the profession. There are very few welfare programs in existence in Ontario.

Under The General Welfare Act there is some provision in some municipalities to permit extraction of teeth, and repair of existing dentures. This is partly supported by the Department of Public Welfare and the community. Beyond that very little, other than the one program we made reference to in our brief, which we administer ourselves for the children of the Mothers' Allowance group, and I think this is one of the real crying needs in the Province of Ontario, the making available if you like, of dental services to those who presently receive welfare benefits, and those in the marginal or medically indigent group. We have a problem in that area.

COMMISSIONER STRACHAN: Well, you have just referred to the program for children under the Ontario Dental Welfare Plan. To what degree is it utilized?

DR. DUNN: The Ontario Dental Welfare Plan is now into its fourth year of operation. We have had an average of, last year we had 22,000 children



June 1952

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COMMISSIONER STANLEY: The next

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COMMISSIONER STANLEY: Well, you have

just referred to the program for children under the Ontario Dental Welfare Plan. To what degree is it utilized? DR. LUTHER: The Ontario Dental Welfare Plan is now into its fourth year of operation. We have had an average of, last year we had 27,000 children





Dunn 11523

eligible each month, and we provided care for 8,970 patients. The percentage is increasing a little bit, but not significantly. In other words, of the 22,21, thousand children approximately eligible each year, approximately a third to 35 to 40% receive some care. We believe that this program needs to be expanded however, to include those beneficiaries who receive benefit under the Ontario Medical Welfare Plan.

At the moment we just have this one small group, and it is not quite sufficient.

COMMISSIONER STRACHAN: Then you state the people under the Ontario Medical Welfare Plan are not covered dentally?

DR. DUNN: That is correct, sir.

THE CHAIRMAN: Other than these ---

DR. DUNN: Other than extraction of teeth and repair of existing dentures in the communities.

COMMISSIONER STRACHAN: Well, speaking of this plan, which has been in operation for four years, as you suggest, what, if any, have been the difficulties in the administration for the Government?

DR. DUNN: I hope this does not sound intemperate, sir, but one of the startling things about this has been its almost complete lack of difficulties. I think this could be confirmed with the Department of Public Welfare of Ontario. We receive each month a grant based on 70¢ per eligible child, and we provide dental services from this fund for all children who seek it. I am unaware over the last eighteen months to almost two years of any valid complaint received from either public or



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COMMISSIONER ...

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... that is correct, sir.

THE CHAIRMAN: ...

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Dunn 11524

profession in respect of the administration of this plan. It is almost entirely devoid of any administrative red tape that might give concern to members of the profession. The dentists realize that they can provide the services and no prior authority is required. The accounts are submitted to the office of the administrative agency, and these accounts are paid on a pro-rated basis, and frankly we have had no difficulties in the administration of the plan whatsoever.

COMMISSIONER McCUTCHEON: You are treating less than a third of the number of children eligible in any one year. Supposing they all presented themselves, what would happen?

DR. DUNN: We would have a problem. As a matter of fact, it was on the basis of demand, this highly conjectural demand, that we attempted to estimate the per capita assessment.

THE CHAIRMAN: The per capita would have to go up?

DR. DUNN: It would have to be a larger pro-rated factor.

THE CHAIRMAN: I suppose in the order of things a hundred percent never do --

DR. DUNN: That is right, and the removal of the economic factor is not in itself a thing which will persuade people to obtain dental services, although many people allege that this is so, but our evidence in any respect is that it is not.

COMMISSIONER STRACHAN: Is this care given full or comprehensive care?





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the number of cases.

THE CHAIRMAN: The few cases would  
...to be met  
...it would have to be a large  
...pro-rata system.  
THE CHAIRMAN: I suppose in the order  
of things a number of cases never do --  
...: That is true, but the  
...of the children is not to have a large  
...will require people to be able to provide services,  
...that is to say, but the  
...is not as great.  
...of the children is not as great.



Dunn 11525

DR. DUNN: We call this a car-  
care service. In other words, we attempt to deal with  
those problems which arise through the tooth decaying  
process. We don't get into orthodontics or other  
processes. We provide the necessary filling and extrac-  
tions, and deal with those injuries to anterior teeth,  
which are so distressing in the child population. We  
realize it is not comprehensive in terms of those impor-  
tant aspects of dentistry which both you and I would like  
to see included, but it does provide a good basic service.

COMMISSIONER STRACHAN: To refer back  
to the cost of this scheme. Based on the regular Ontario  
fee schedule, what is the per capita cost?

DR. DUNN: Last year the average  
payment per patient was \$20.76. If we augmented that to  
100%, that is the O.D.A. fee schedule, it would be in  
the neighbourhood of \$29.53. Keep in mind again though,  
that that service is a basic caries care program, and  
does not include the more elaborate dental procedures.  
A little less than \$30.00.

THE CHAIRMAN: \$30.00 per patient who  
received services?

DR. DUNN: That is correct, sir, if we  
apply the full schedule. It was \$20.76 on the pro-rated  
basis.

THE CHAIRMAN: And that is so, that  
if you were trying to look at an average to bring it down  
to a per capita basis, we would have to go to 100% and  
divide it back?

DR. DUNN: I think that is correct, but



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same material. In other words, we should be able to find it.  
These people, which are the teeth showing  
in the right side of the head on either  
side, as a rule, the necessary filling and ex-  
posed, and that with these teeth is a very low tooth.

It is not necessary to find it at this time.  
I have not yet seen any of the teeth and I would like  
to see it, but it does not seem to be a very good piece of  
material. To make back  
the cost of this material, I have on the regular rate of

18. This is a copy of the

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Dunn 11526

I am not sure I follow it.

COMMISSIONER STRACHAN: Before leaving the subject of dentistry for children, I am going to ask you a question which I asked Dean Ellis previously. I asked him because of his experience and personal knowledge of dental matters in New Zealand and Australia, but I am asking you the questions because of the fact that you are a paedodontist.

Is dental service for children easier and simpler than for adults, and combined with that, can the fact be reconciled that New Zealand has females with two years training rendering dental care to children, while North America recognizes that two of our most important specialities, paedodonture and orthodonture, are necessary and even essential for the proper care of children?

DR. DUNN: First of all, Dr. Strachan, I thank you for the promotion you have given me. I am not a paedodontist. Dr. Nikiforuk, however, is, but as one who has had a good deal of interest in dentistry for children I cannot believe that there is any more important area of dental services than that directed towards the child population.

Teeth are important for three reasons, mastication, appearance and speech. With the child there is added significance in that they are important in the proper growth and development of the jaws and face. In many respects the primary dentist is even more important to the individual than the permanent dentist. Although I will admit that this will conjure up some interesting





Dunn 11527

arguments, because of the fact that the primary dentist generally leaves by the time we are thirteen years of age.

We in Canadian dentistry tend to give emphasis to the preventive aspects of practice, which are more appropriately directed to the youngest age group.

We believe that the best dental service, or the people most competent to provide good dental service, should be directing their attention to the child population, rather than the other way around.

THE CHAIRMAN: Your reference is to the dental nurse in the elementary school system in New Zealand, who does, I understand, fillings principally and dental hygiene instruction, and does not purport to do any of these other elements you mentioned, just as under your own program here in Ontario, you don't purport to do these other things, under this program we were just talking about a few minutes ago, orthodonture and so forth are not covered in the children of a group who receive Mothers' Allowance, so that within the narrow field in which they do function, do you say that there is no benefit to be seen from the employment of nurses who have had two years training in dental filling as is done in New Zealand, that the scheme they have in New Zealand is useless?

DR. DUNN: No, sir, I don't think I have made that comment.

THE CHAIRMAN: I am just wondering if you go that far, that is all.

DR. DUNN: I don't believe that there is any great evidence to show that the ultimate result of





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...by the fact that we are thirteen years of age.  
...as an Ontario conditionally sound to give

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...that the element they have in New Zealand

...is the fact  
...No, sir, I don't think I  
...that don't  
...I am just wondering if  
...that is all.  
...I don't believe that there  
...to show that the results of



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the program has been significantly beneficial. I think within the narrow limits of the program as you have outlined that these people have provided a service which has been acceptable.



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the program has been significantly reduced. I think  
within the narrow limits of the program as you have out-  
lined, that we have been able to provide  
the best results.

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THE CHAIRMAN: You see, look at it in this light. Is it better they have that service or no service at all? If the choice is between that and zero, are they doing something worthwhile?

DR. DUNN: Again I have not seen the program.

THE CHAIRMAN: Dr. Ellis did discuss it.

DEAN ELLIS: May I add one comment to what I had to say the other day in this respect? Speaking of the New Zealand dental nurse, they have been trained to do a simple filling, they have been trained to do it well and they can do it. However, the end result of the New Zealand dental nurse program is rather significant.

At the beginning of the Second World War they were recruiting men for the services, aged 20 and 21. The mouths of the young New Zealand men who had come through the New Zealand dental program in the schools were the worst off in the Commonwealth, I guess perhaps in the world. There were more New Zealand recruits with full dentures or partial dentures than any other group of army or people in the world. This is well documented. It is not because of the bad fillings particularly but it is because of the fact that they concentrated on service, they did not concentrate on health education. The young men, by the time they got out of the coverage of the scheme, didn't care a bit about their teeth and they let them go and they lost them and then ultimately required dentures. The health



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in this light. Is it better they have that service  
or no service at all? If the choice is between that

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out of the coverage of the scheme, didn't care a bit

about their teeth and they let them go and they lost

them and then ultimately required dentures. The health



Ellis

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education, public health education aspect simply broke down completely and it didn't carry through.

Perhaps you can say for a few years the children had no toothache, but the results did not carry through, and this is documented completely.

COMMISSIONER BALTZAN: Could it be summarized that they did good work, these people, but overlooked the evil consequences?

DEAN ELLIS: Yes. They were focusing their attention in patching up holes in teeth, but there was no consideration of the comprehensive aspects of the development of this mouth and the subsequent requirements as far as life was concerned.

THE CHAIRMAN: Does that leave us in this position, that they would have had any more teeth even if the holes hadn't been filled?

DEAN ELLIS: No, but I think it would be true to say that when the scheme in Canada in comparison ---

THE CHAIRMAN: No, we are talking about what was there. The suggestion seems to be that they were worse off because they filled the cavities.

DEAN ELLIS: I suggested in a period of time they were better off, they had no tooth-ache, but they had no appreciation of what was being done and therefore the scheme in my opinion is of little value from a permanent standpoint.

THE CHAIRMAN: If it needed support, they should do education along with it?

DEAN ELLIS: In other words, the hygienist





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Perhaps you can say for a few years

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COMMISSIONER BARTON: Could it be

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overlooked the evil consequences?

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was no consideration of the comprehensive aspects of the  
development of this mouth and the important consequences  
as far as life was concerned.

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THE CHAIRMAN: No, we are talking

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of time they were better off, they had no tooth-aches,  
but they had no satisfaction of what was being done and  
therefore the scheme in my opinion is of little value  
from a permanent standpoint.

There should be education along with it

DR. BARTON: In other words, the people



Ellis

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4 with the program of health education and oral prophylaxy,  
5 they are going to be better off under that scheme than  
6 the New Zealand scheme.

7 COMMISSIONER STRACHAN: I did elevate  
8 you, but I had reference to the fact that you did a lot  
9 of children's dentistry while you were in practice.

10 did a s The term "recruit" was just mentioned,  
11 and I think it is appropriate that we should establish  
12 from the two bodies represented here what has been done  
13 and what is being done towards recruitment of dental  
14 students and personnel.

15 DR. DUNN: This has been an area  
16 which has caused us, I would like to think, a considerable  
17 degree of justifiable pride. Three or four years ago  
18 it became rather apparent that if we were significantly  
19 to add to our numbers we could not depend upon other  
20 people recruiting students for us, we had to do it  
21 ourselves. The profession established a national  
22 recruitment committee within the framework of the  
23 Canadian Dental Association, and subsequent to that  
24 establishment some nine provincial recruitment committees  
25 have been organized as well. Ontario has been fortunate  
26 in that it has a very strong recruitment committee  
27 comprised of three groups, the Royal College of Dental  
28 Surgeons, the Ontario Dental Association and the Dental  
29 Alumni Association of Toronto. We have worked  
30 assiduously with the guidance people, with the various  
high schools, we have put information into the annual  
careers issue of the Canadian High News, and the efforts  
of the Association I think have been made most apparent



with the program of health education and oral prophylaxis, they are going to be better off under that scheme than the New Zealand scheme.

COMMISSIONER STANLEY: I did elaborate you, but I had reference to the fact that you did a lot of children's dentistry while you were in practice. The term "dentist" was just mentioned, and I think it is appropriate that we should establish from the two bodies represented here what has been done and what is being done towards recruitment of dental students and personnel.

DR. JAMES: This has been an answer which has caused us, I would like to think, a considerable amount of justifiable pride. Three or four years ago it became rather apparent that if we were significantly to add to our numbers we could not depend upon other people's recruiting grounds for us, we had to do it ourselves. The profession established a national recruitment committee within the framework of the Canadian Dental Association, and subsequent to that recruitment committee have provincial recruitment committees have been organized as well. Ontario has been fortunate in that it has a very strong recruitment committee composed of three groups, the Royal College of Dental Surgeons, the Ontario Dental Association and the Ontario Dental Association of Ontario. We have worked very closely with the various groups, with the various dental schools, we have put information into the annual reports of the Ontario Dental Association, and the efforts of the Association I think have been most apparent.





Ellis

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4 over the last two years with the greatly augmented number  
5 of applications we have received, and also significantly  
6 elevated the academic quality of these applications.

7 In addition to this general approach  
8 we felt a particular need to recruit students from the  
9 rural areas. Dr. Granger at the Faculty of Dentistry  
10 did a study which indicated, I think, beyond any question  
11 that people recruited from the smaller communities  
12 were more likely to return to them; highly unlikely to  
13 recruit a man from Metropolitan Toronto and expect him  
14 to go out to a very small community.

15 So we have placed great emphasis on  
16 recruitment from the rural communities, and again we  
17 have found from the number of applications received that  
18 this program has been effective.

19 It is my understanding, and the  
20 Dean will correct me if I am wrong, that even at this  
21 early date there are 400 applications in the Registry  
22 at Simcoe Hall for the 15 or 20 places available in  
23 the Fall. Of great significance to us was that last  
24 year 74.8% of the applicants going into pre-professional  
25 year came to us with grade 13 second class schools or  
26 better, whereas the previous year I think that figures  
27 was 40%, 41%. And we have also found that of those  
28 people who came to us with 63% or less about 50% of this  
29 group will have some type of condition in the pre-  
30 professional year. Therefore if we can raise that  
academic stature to the 63%, 64% level we are going to  
have an academic mortality. I think our program has  
been effective and will be effective in that area as well.

over the last two years with the greatly augmented number of applications we have received, and also significantly elevated the academic quality of these applications.

In addition to this general approach we felt a particular need to recruit students from the rural areas. Dr. Gumpert at the Faculty of Dentistry did a study which indicated, I think, beyond any question that people recruited from the smaller communities were more likely to return to them; highly unlikely to recruit a man from Metropolitan Toronto and expect him to go out to a very small community.

So we have placed great emphasis on recruitment from the rural communities, and again we have found from the number of applications received that this program has been effective.

It is my understanding, and this can only correct me if I am wrong, that even at this early date there are 400 applications in the Faculty at Ottawa Hall for the 15 or 20 places available in the fall. Of great significance to us was that last year 75% of the applicants going into pre-professional were in the 15 or 20 places available in the fall. Of great significance to us was that last year, whereas the previous year I think that figure was 50%, 50%. And we have also found that of those people who come to us with 80% or less about 60% of this group will have some type of condition in the pre-professional year. Therefore if we can raise that percentage to the 75% level we are going to have an excellent opportunity. I think our program has been effective and will be continuing in that area as well.



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4 COMMISSIONER STRACHAN: Thank you,  
5 Dr. Dunn.

6 I suppose we must face the facts of  
7 life, and in the absence of a fellow Commissioner this  
8 morning I will ask a question which I am sure he would  
9 place before you.

10 Would you be in favour of the intro-  
11 duction of a compulsory, comprehensive, government tax-  
12 supported program for dental services?

13 DR. DUNN: I think the answer to the  
14 question, sir, is no.

15 COMMISSIONER STRACHAN: Why not?

16 DR. DUNN: If we mean by comprehensive  
17 that comprehensive services or services should be  
18 available comprehensively to the public, those who need  
19 and demand those services, of course we would agree.  
20 I do not believe, however -- and I am sure this Commission  
21 has heard many groups philosophize on this -- but we  
22 believe the best care results when there is some individual  
23 and personal responsibility. We believe in our pro-  
24 fession that it is a rather sad commentary today that  
25 so many people will dwell upon the provision of treat-  
26 ment services, when through the application of knowledge  
27 and understanding already available a very great  
28 percentage of the problem could be eliminated.

29 Dental caries is almost entirely  
30 preventable through the application of knowledge and  
understanding which we already possess.

We believe that the type of plan of  
which you speak tends to shift the education completely







Dunn

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4 from education, research, prevention and places it  
5 into treatment, and we cannot see ultimately that there  
6 will be a great benefit derived thereby.

7 I think, too, I might as well be candid  
8 and suggest to you that our profession would have some  
9 concerns with the type of plan you state. We do not  
10 believe you can take human beings, with their many  
11 requirements, and make them into a mould. We are  
12 concerned with divided responsibility and responsibility  
13 for the care of our patients. At least I must be honest  
14 and say that we are somewhat concerned with a large  
15 governmental bureaucracy which would tend to have a  
16 great say in the provision of treatment services.

17 I think it is a fact that I believe  
18 Dr. Gullett has indicated before this Commission that  
19 in the United Kingdom at the present time for every  
20 eight dentists actually giving dental care there is one  
21 full-time administrative person. Perhaps Professor  
22 Parkinson's law will be ---

23 COMMISSIONER STRACHAN: You mean a  
24 person in dentistry?

25 DR. DUNN: No, one full-time person  
26 for every eight, and out of the aggregate number a good  
27 many would be dentists. But there would be clerical  
28 help, statistical help and that sort of thing.

29 Another thing we fear would be the  
30 negation of our profession's most pertinent efforts.  
It is rather significant that in the Association we have  
some 22 or 23 committees that work in different areas.  
There are a few of those committees, such as by-laws,



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into treatment, and we cannot see ultimately that there  
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Dr. Fulbright has indicated in the Commission that  
in the United Kingdom at the present time the way  
might be set up actually giving dental care there is one  
full-time administrative person. Perhaps Professor  
... will be ---

COMMISSIONER: You mean a  
... in fact?  
Dr. Fulbright: No, one full-time person  
for every eight, and out of the answers: number a word  
... would be essential, but there would be clinical  
... statistical help and that sort of thing.

... think us that would be the  
... of the profession's most important efforts.  
It is rather difficult to see in the Association we have  
... of the committee, the work is different areas.  
... and a lot of those committees, such as hygiene,





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Dunn

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4 which are internal to the Association, but the vast  
5 majority of them are working in an attempt to promote  
6 those things which will help the Canadian people. I have  
7 recognized and seen in other jurisdictions that many  
8 of these professional organizations tend to become  
9 negotiating bodies trying to get improvements on some  
10 existing plans. We think this would be unfortunate.

11 And, finally, I think we are somewhat  
12 concerned with the possible insecurity of such schemes,  
13 because so frequently many of the terms of reference  
14 of them are predicated perhaps more on political  
15 considerations than they are upon the health of the people  
16 we are trying to serve.

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We believe that dental services should be made comprehensively available to those who need them and those who want them and I think we should work towards that end. For the type of scheme which you have mentioned, our profession would not be in favour.

COMMISSIONER STRACHAN: Then, I think you have answered what would have been my last question; could the standard of dental service be raised or even maintained under such a scheme?

DR. DUNN: This again is rather conjectural but again I am unaware of any evidence of any existing plan which has elevated or has been the cause of elevating standards of service. I do not suggest for a minute that the standards will go down but I do not see anything inherent in the plan to keep them up.

I think the tendency may be, in this standardization which almost inevitably follows, there would be perhaps a disenchantment to dentists to attempt to alleviate this so they can provide more superior service because they might not be able to provide these efforts within the framework of a rather rigid plan.

COMMISSIONER STRACHAN: Then, under such a scheme, who could possibly decide when and where the various techniques might be used as, for example, the use of Silicate or gold foil - silicates or gold inlay - silicates or porcelain jacket crowns - amalgam or gold inlay - fixed or removable bridge - fixed bridge or partial denture - restoration of remaining teeth and insertion of partial denture or complete extraction and





to be that kind of service

on the other hand, we have to be able to take the

and then and then we want them and I think we

which you have mentioned, our professor would not be

in town.

COMMISSIONER: Then, I think

you have answered what would have been my last question;

and the standard of dental service be raised or even

maintained under such a scheme?

But again I am unaware of any evidence of any

existing plan which has been put on foot since the war

of elevating standards of service. I do not suggest

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would be perhaps a disadvantage to attempt to attempt

to alleviate this so they can provide more service

service because they might not be able to provide these

efforts within the framework of a rather rigid plan.

COMMISSIONER: Then, what

such a scheme, which would possibly decide when and where

the various changes might be made as far as

the use of 14 karats or gold fill - silver or gold

work - silver or porcelain jacket crowns - dentures

to solid dentures - the use of removable dentures - fixed dentures

of dentures - dentures - dentures - dentures - dentures

dentures - dentures - dentures - dentures - dentures



Dunn

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3 full denture - periodontal treatment or extraction -  
4 partial denture with or without clasps - partial denture  
5 with wrought bar and clasps or cast partial in white  
6 metal or gold - full dentures done by wax bite technique  
7 or done by proper impressions, bite registration, try in,  
8 adjustments and insertion resulting in dentogenic  
9 dentures - the use of straight acrylic or cast metal  
10 base in partial or full denture work?

11 DR. DUNN: I think you have emphasized  
12 one of our concerns that there is such a variety of  
13 services possible that the attempt to standardize proce-  
14 dures of this nature can be most difficult. I think  
15 these services must, almost entirely, be based upon the  
16 particular case and the patient who presents himself  
17 for treatment to a dentist.

18 I think it is only the dentist that  
19 can make these decisions when all the radiological  
20 and clinical facts are made known to him and, of course,  
21 only the patient who can accept or reject these details  
22 for treatment. I think this is one of the first points  
23 I made, this need to conform. This bothers us because  
24 we realize there are so many variables made contingent  
25 upon the condition which the patient presents.

26 COMMISSIONER STRACHAN: Then, if a  
27 voluntary plan for dental service were instituted, how  
28 would you propose to make dental service available to  
29 those who could not pay?

30 DR. DUNN: Here again, I think we must  
be rather candid in Ontario and say the only organization,  
the Ontario Dental Association, with the Royal College



full denture - peristaltic treatment on extraction -  
 partial denture - with or without clasps - partial denture  
 with wrought iron and clasps - cast partial in white  
 metal on gold - full dentures done by wax bite technique  
 on done by proper impressions, bite registration, try in,  
 adjustments and insertion resulting in dentographs  
 dentures - the use of straight acrylic or cast metal  
 bases in partial or full denture work

DR. DUBOIS: I think you have explained  
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 and clinical facts are made known to him and, of course,  
 only the patient who can accept or reject these things  
 for treatment. I think this is one of the great problems  
 I state, this need to conform. This harmony or balance  
 we realize there are so many variables made contingent  
 upon the condition which the patient presents.

DR. DUBOIS: I think, if  
 voluntary plan on dental services were established, I  
 would you proceed to make dental service available to  
 those who could not pay.

DR. DUBOIS: I think it is  
 a matter of time in order to have the dental service  
 the American Dental Association, when the dental service





Dunn

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of Dental Surgeons, has made much effort on its own to deal with this problem. We have looked for guidance to our national organization in this area. It is possible, I suppose, for some form of governmentally assisted programs for an acceptable insurance program which may be developed but even at this stage, because of the characteristics of dental and oral disease, all I would attempt to deal with, at first, is we really have no acceptable prepayment plan as yet. We have certain proposals based on knowledge which we possess and in conversations with two medical groups we have not found our proposals overwhelmingly accepted because, in essence, we would attempt to provide care for those things which people normally do not have too much difficulty providing for themselves.

We believe that this dental health index which we have supported here will be of some assistance in determining the needs of the adult people in Canada. At the moment, I am afraid we do not have any real good suggestion for the question which you have just posed.

COMMISSIONER STRACHAN: I think I have covered most of the points. I do not know whether I have emphasized all these points which these gentlemen would like to put before us.

COMMISSIONER McCUTCHEON: Dr. Dunn, this has been a very interesting brief. Some of your recommendations, of course, I think are outside of our terms of reference in that they are directed to the legislation of the Province of Ontario but they have



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to deal with this problem. We have looked for guidance  
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...I am, I think,  
this has been a very interesting lunch. Some of your  
...of course, I think the outside of our  
...is that they are directed to the  
...of the ... but they have



Dunn

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been helpful.

Do the two groups that are represented here this morning support, without reservation, the recommendations that were made to us by the Canadian Dental Association?

DR. DUNN: Yes, sir, we do.

COMMISSIONER McCUTCHEON: Thank you very much.

COMMISSIONER STRACHAN: I wonder if any of the others have anything to say?

THE CHAIRMAN: Are there any other observations someone would like to make?

DR. LECKIE: I would like to thank the Commission for hearing us this morning and the way the questions have been handled, the informality of it has been very stimulating. We hope we have been able to supply you with information that will be useful.

THE CHAIRMAN: Thank you very much, it has been very helpful and indeed an interesting morning.





To the two groups that are represented

here this morning, support, without reservation, the  
recommendations that were made to us by the Canadian

DR. DAVIS: Yes, sir, we do.

COMMISSIONER JOHNSON: Thank you.

very much.

MR. LESTER STEWART: I wonder if

any of the others have anything to say?

THE CHAIRMAN: Are there any other

observations anyone would like to make?

MR. LESTER: I would like to thank

the Commission for holding this morning and for

the questions have been handled, the information

of it has been very stimulating. We hope we have been

able to supply you with information that will be useful.

THE CHAIRMAN: Thank you very much.

It has been very helpful and indeed an interesting



THE SECRETARY: Mr. Chairman, the next brief is that of Dr. P. Laird Gibbs and it will be known as Exhibit No. 326.

--- EXHIBIT NO. 326: Submission of Dr. P. Laird Gibbs.

SUBMISSION OF DR. P. LAIRD GIBBS

THE CHAIRMAN: Dr. Gibbs, you are appearing as an individual so would you just give us an idea of your background?

DR. GIBBS: Yes. I am a practising general practitioner in Dresden, Ontario; a graduate of the University of Western Ontario of 1952. I spent some 16 years in the Air Force as a radiographer and some 7 years as a medical officer. Presently, I am coroner of Kent and Lambton Counties; I am on the Board of the Sydenham Hospital, representing the Town of Dresden and I have been in practice approximately three-and-half years.

THE CHAIRMAN: Now you wish to deal with your recommendations?

DR. GIBBS: Yes.

It is suggested that if a national health scheme is implemented it should have the following qualifications:

(a) It should be compulsory; this implies that no premium is collected but that every Canadian resident is automatically protected against medical expense.



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THE CHAIRMAN: Mr. Chairman, the next point is that of Dr. P. Laird Gibbs and it will be known as Exhibit No. 326.

--- EXHIBIT NO. 326: Submission of Dr. P. Laird Gibbs.

SUBMISSION OF DR. P. LAIRD GIBBS

THE CHAIRMAN: Dr. Gibbs, you are appearing as an individual so would you just give us an idea of your background?

DR. GIBBS: Yes. I am a practising general practitioner in London, Ontario; a graduate of the University of Western Ontario of 1952. I spent some 11 years in the Air Force as a radiographer and some 7 years as a medical officer. Presently, I am a member of Kent and Lambton Counties; I am on the Board of the St. John's Hospital, representing the town of London and I have been in practice approximately three and a half years.

THE CHAIRMAN: Now you wish to deal with your recommendations?

It is suggested that it is a matter of public health and it should have the following recommendations:

- 1. That the Government should...
- 2. That the Government should...
- 3. That the Government should...
- 4. That the Government should...
- 5. That the Government should...





Gibbs

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THE CHAIRMAN: I do not want to interrupt but you use the word "compulsory"; do you not mean comprehensive? Compulsory means you must belong to it, you must accept its services, you must do something; is that what you have in mind?

DR. GIBBS: What I am saying is, if you are a Canadian in Canada you have medical services, period.

THE CHAIRMAN: But through this one program, through this one scheme?

DR. GIBBS: Yes.

THE CHAIRMAN: And you cannot go and get it anywhere else?

DR. GIBBS: No, I do not imply that.

THE CHAIRMAN: I was wondering if that is what you had in mind.

COMMISSIONER VAN WART: You mean a complete medical program?

DR. GIBBS: Yes, available to everyone without cost.

THE CHAIRMAN: You are talking about a program universally available to all those who want it?

DR. GIBBS: Correct.

COMMISSIONER VAN WART: All health services?

DR. GIBBS: All health services.

(b) The remuneration of the physician should be on a fee-for-service basis and based on present provincial fee schedules. The fee schedule should



THE CHAIRMAN: I do not want to

interrupt but you use the word "comprehensive"; do you  
not mean comprehensive? Comprehensive means you must  
belong to it, you must accept its services, you must  
do something; is that what you have in mind?

DR. STARR: What I am saying is, if

you are a Canadian in Canada you have medical services,

THE CHAIRMAN: But through this one

scheme, through this one scheme?

THE CHAIRMAN: And you cannot go and

get it anywhere else?

THE CHAIRMAN: I was wondering if that

is what you had in mind.

COMMISSIONER VAN WAT: You could a

complete medical program.

DR. STARR: Yes, available to everyone

THE CHAIRMAN: You are talking about a

universal service available to all those who want it?

COMMISSIONER VAN WAT: All within

service?

DR. STARR: All within service.

(b) The responsibility of the physician

should be on a case-by-case basis

and not on a general basis.

rehabilitation. The one scheme is what I



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be mandatory for all agencies outside of the plan, i.e. for DVA, Indian Affairs, Workmen's Compensation Board, etc., so that there is no longer a disparity between fees for the same services rendered for different agencies.

(c) There should continue, as at present, freedom of choice of physician by the patient and vice versa.

(d) The mechanics of collection by the physician should be as simple as possible, preferably with the adoption of the methodology of the present W.M.S., P.S.I. and M.W.P.

(e) There should be no deterrent fee unless there can be arranged some other method for its collection than through the physician since in most cases it would never be paid by the patient.

(f) To ensure that all members of the community contribute to the support of the plan the provincial sales taxes should permit of no exemptions for food, fuel, clothing, shelter, gasoline, etc. Thus those who pay no income tax will at least be contributing in minor fashion for their medical coverage.





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the following for all and also for  
of the U.S. Army, Navy,  
Affairs, Department of  
etc., and the State is to forward  
legislative bodies from the time

also.

(a) There should continue to be  
present, in order to ensure of  
by the patient and vice versa.

(b) The need for education by  
the physician should be a matter of  
necessity, particularly with the education  
of the methodology of the research  
U.S.A., P.I. and C.I.

(c) There should be no requirement  
which there can be applied to  
order matters for the education and  
through the physician's role in  
cases it would never be felt that the  
attitude.

(d) A measure that will  
the community contribute to the support  
in the form of the provision of  
a solid basis of no one other than  
time, etc. Thus there is a  
in the tax which is to be considered  
and in the case of the



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(g) The plan should be administered on a provincial basis by a Commission similar to that which in Ontario operates the Ontario Hospital Services Act. It is also suggested that to continue the similarity, the members of the Commission should be drawn from the ranks of physicians who have practised in the province and who are in good standing in the College of Physicians and Surgeons of the appropriate Provincial College.

THE CHAIRMAN: Now, in the last suggestion there about the Commission, that the members of the Commission should be drawn from the ranks of physicians, do you mean the entire Commission should be physicians?

DR. GIBBS: Yes, sir.

THE CHAIRMAN: And even though the whole matter is tax-supported you would not give government any representation on the administrative body?

DR. GIBBS: Who am I to say?

THE CHAIRMAN: Well, you have said here and I am asking if your thinking has carried you through to that?

DR. GIBBS: Physicians should form the majority of the Commission.

THE CHAIRMAN: Now then, you speak of a national health scheme but the body of your text and



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(8) The bill should be administered  
in a provincial basis by a Commission  
similar to that which in Ontario  
operates the Ontario Hospital Board.  
Not. It is also suggested that to  
continue the similarity, the members  
of the Commission should be drawn  
from the ranks of physicians who have  
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ce. Provincial College.  
THE CHAIRMAN: Now, in the last sugges-  
tion there about the Commission, that the members of  
the Commission should be drawn from the ranks of  
physicians, do you mean the entire Commission should be  
physicians?  
MR. O'BRYEN: Yes, sir.  
THE CHAIRMAN: And even though the  
whole matter is tax-supported you would not give  
Government any representation on the administrative  
body?  
MR. O'BRYEN: Who am I to say?  
THE CHAIRMAN: Well, you have said  
here and I am asking if you are thinking that would you  
thought to that?  
MR. O'BRYEN: Physicians should form  
the majority in the Commission.  
THE CHAIRMAN: Now, you speak of  
a national health scheme but the body in your text an





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the recommendations appear to deal only with physician services?

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DR. GIBBS: Yes.

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THE CHAIRMAN: So that your national health scheme, we must - is it right that you are talking of a physician service scheme?

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DR. GIBBS: That is right.

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THE CHAIRMAN: Because the national health scheme includes dentistry, nursing, etc., and the program you would recommend to set out is this one which would be universally available to everybody, paid for through taxes?

14

DR. GIBBS: Correct.

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THE CHAIRMAN: And you would broaden the base of taxation so that in sales tax you would offer no exemptions?

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DR. GIBBS: Right.

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DR. GIBBS: That is right.

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THE CHAIRMAN: Regardless of how low the income of the person was?

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DR. GIBBS: Yes, sir.

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THE CHAIRMAN: Now, you say there should be freedom of choice by the physician; we have a plan universally available to anyone, anyone requiring the services of a physician must have service available to him, correct?

28

DR. GIBBS: Yes.

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THE CHAIRMAN: And you say that you

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the recommendations I want to deal only with physician

THE CHAIRMAN: So that your national

health scheme, we want - is it right that you are

thinking of a physician service scheme?

DR. CIBBS: That is right.

THE CHAIRMAN: Because the national

health scheme includes dentistry, nursing, etc., and

the program you would recommend to set out is this

one which would be universally available to everybody,

aid for through taxes?

THE CHAIRMAN: And you would increase

the rate of taxation so that in sales tax you would

have no exemptions?

THE CHAIRMAN: So everybody would be

making some contribution?

THE CHAIRMAN: Regardless of how low

the income of the person was?

THE CHAIRMAN: Now, you say there

should be freedom of choice by the physician; we have

an universally available to any one, another, waiting

to see a doctor of a certain kind have been available

THE CHAIRMAN: And you say that you



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would have the freedom to choose a physician?

DR. GIBBS: As at the present time.

THE CHAIRMAN: And vice versa; you mean the physician would be free to say, "Well, I don't choose to treat Mr. X."?

DR. GIBBS: As at the present time.

THE CHAIRMAN: How do you reconcile that? If everybody is entitled to service, that some physicians might be entitled to not perform their services?

DR. GIBBS: The majority of cases there is a choice, there is certainly a choice in my own town.

THE CHAIRMAN: But if all the physicians in your town just developed the notion that they were not going to treat Mr. X, who is under your program entitled to be treated ---?

DR. GIBBS: He has the freedom of choice of any doctor anywhere.

THE CHAIRMAN: He could go to Toronto or Winnipeg?

DR. GIBBS: Or Boston or Chatham or Petrolia, as at the present time.





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Would have the freedom to choose a physician?  
MR. GIBBS: As at the present time.

THE CHAIRMAN: And vice versa; you

mean the physician would be free to say, "Well, I

don't choose to treat Mr. X."

MR. GIBBS: As at the present time.

That? If everybody is entitled to service, that some  
physicians might be entitled to not perform their  
services?

MR. GIBBS: The majority of cases

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own town.

THE CHAIRMAN: But if all the physicians

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THE CHAIRMAN: He could go to Toronto

or Winnipeg?

MR. GIBBS: Or Boston or London or

Petrolia, as at the present time.



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3 COMMISSIONER VAN WART: On page one  
4 of your recommendations (a) you use the word compulsory.  
5 You say "this implies that no premium is collected but  
6 that every Canadian resident is automatically protected  
7 against medical expense". I don't see how the word  
8 "compulsory" is applicable.

9 DR. GIBBS: Well, the Chairman has  
10 already pointed out to me, and I accept it, that perhaps  
11 I used the wrong word. This is our recommendation: As  
12 I read it, it is exactly what has been discussed here.  
13 Exactly the same wording and I think the same implica-  
14 tion; universal medical physician provided service is  
15 what I should be talking about.

16 THE CHAIRMAN: We understand that.

17 COMMISSIONER VAN WART: I just wanted  
18 to see if you had the same thing in mind. That is all.

19 COMMISSIONER BALTZAN: Doctor, I only  
20 have one thing that I would like to ask you. On page  
21 2, second last paragraph, last three lines:

22 "It should also be reported that this  
23 "writer is one of the one in three  
24 "members of the Canadian Medical  
25 "Profession who is not a member of the  
26 "Canadian Medical Association."

27 I do not ask you anything about the rights or privileges.  
28 This is your privilege. We all understand it. I just  
29 wanted to know, or would you care to say why you point  
30 out this exception. Is there any reason why you inserted  
it?

DR. GIBBS: Yes, because obviously I do



of your recommendations (I am not the word "conspiracy,"  
You say "this is a word that no one is collected but  
that every Canadian is aware is automatically protected  
against medical excesses". I don't see how the word  
"conspiracy" is applied.

DR. GIBBS: Well, the Chairman has  
already pointed out to me, and I accept it, that perhaps  
I used the wrong word. This is our recommendation. As  
I read it, it is exactly what has been discussed here.  
Exactly the same wording and I think the same intention.  
I think; universal medical education provided advice is  
what I should be talking about.

THE CHAIRMAN: We understand that.  
COMMISSIONER VAN WART: I just wanted  
to see if you had the same thing in mind. That is all.  
COMMISSIONER BATTAN: Doctor, I only  
have one thing that I would like to ask you. On page  
3, second last paragraph, last three lines:

"It should also be reported that this  
"writer is one of the one in three  
"members of the Canadian Medical  
"Association who is not a member of the  
"Canadian Medical Association."

I do not see how anything about the object of the  
this is your criticism. We all understand it. I just  
wanted to know, or would you care to say why you point  
out this except on. Is there any reason why you inserted

DR. GIBBS: Yes, because of course I do





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not agree with the Canadian Medical Association policy.

COMMISSIONER BALTZAN: That is the reason?

DR. GIBBS: Yes.

COMMISSIONER BALTZAN: I do not care to have any more. Thank you.

COMMISSIONER McCUTCHEON: Dr. Gibbs, you start out your recommendations with the words "It is suggested that if a national health scheme is implemented ..." and that is what you have in the main body of your brief, but are you advocating any particular scheme or are you simply saying if there is a scheme, then this is the line that it should take?

DR. GIBBS: If there is a scheme, then I think this is the line it should take for reasons which I have outlined in the brief.

COMMISSIONER McCUTCHEON: Are you saying there should be a scheme?

DR. GIBBS: Personally, I am reasonably satisfied with the way things are now.

COMMISSIONER McCUTCHEON: So you are not recommending ---

DR. GIBBS: Reasonably satisfied.

COMMISSIONER McCUTCHEON: --- a scheme?

DR. GIBBS: But there seems to be a gerrymandering for a scheme of this, or some similar type and I would like to put across by this presentation today some of the things that "bug," if I may use the word, general practitioners and that if there is to be a scheme, some of my recommendations should be contained within it.



the same with the National Association of...

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to have any more. Thank you.

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You start out your recommendations with the words "If

is suggested that a national health scheme is

indicated..." and that is what you have in the main

body of your paper, but now you are coming to the particular

scheme you are now recommending. It is a scheme,

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which I have outlined in the paper.

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Gibbs

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COMMISSIONER McCUTCHEON: Are you saying that there should be a scheme or not?

DR. GIBBS: No.

COMMISSIONER McCUTCHEON: Thank you.

THE CHAIRMAN: We understand the proposition you have made. You have spelled out quite fully the income implications and where the money comes, on page 10, and you see some discrimination in the way the general practitioner is dealt with when it comes to this service, as I understand it.

DR. GIBBS: Yes.

THE CHAIRMAN: In relation to item (b) page 1?

DR. GIBBS: Yes.

THE CHAIRMAN: I think we understand your position quite fully Dr. Gibbs and are grateful to you for having come forward with a personal brief and with your explanation of it. I think we understand your position, that things are all right, generally speaking, as they are with some exceptions which you think discriminate against general practitioners, but if there is to be a change, then you think it should follow these lines rather than some others that have been suggested.

DR. GIBBS: That is correct sir.

THE CHAIRMAN: Thank you very much sir. We will now take a short recess.

---Short recess





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COMMITTEE: I believe: Are you

saying that there should be a report on not?

THE CHAIRMAN: We understand the

proposition you have made. You have spelled out quite  
fully the income implications and where the money comes,  
on page 10, and you see some discrimination in the way  
the general practitioner is dealt with when it comes to  
this service, as I understand it.

THE CHAIRMAN: In relation to item (b)

page 11

OK. 1982: Yes.

THE CHAIRMAN: I think we understand  
your position quite fully Dr. Gibbs and are grateful to  
you for having come forward with a personal belief and  
with your explanation of it. I think we understand your  
position, that there are all right, generally speaking,  
as there are with some exceptions which you think  
discriminate against general practitioners, but if there  
is to be a change, then you think it should follow these  
lines rather than some others that have been suggested.  
Dr. Gibbs: That is correct sir.

THE CHAIRMAN: Thank you very much.

11. We will now take a short recess.



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THE SECRETARY: Mr. Chairman, the next submission from the Canadian Rheumatism Association will be presented by Dr. Ogryzlo. This will be known as exhibit 327 and the doctor will read from a statement specially prepared for this purpose.

---EXHIBIT NO. 327: Submission by the  
Canadian Rheumatism  
Association.

SUBMISSION OF  
CANADIAN RHEUMATISM ASSOCIATION

APPEARANCES: Dr. M.A. Ogryzlo  
Dr. H.A. Smythe

DR. OGRYZLO: I am Dr. Ogryzlo, sir, and lady and gentlemen of the Commission and this is Dr. Smythe who is Chairman of the Health Committee of the Canadian Rheumatism Association.

THE CHAIRMAN: Just take a chair, please.

DR. OGRYZLO: The Canadian Rheumatism Association is an organization composed of physicians with a common interest in the better understanding, treatment and prevention of arthritic and rheumatic diseases. It includes internists with a special interest in the rheumatic diseases, research workers in the basic medical sciences, family physicians, orthopedic surgeons and specialists in physical medicine and rehabilitation. The Association represents the majority of those physicians who are engaged in the teaching of rheumatic diseases



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1 THE CHAIRMAN: Mr. Chairman, the next  
 2 submission from the Canadian Rheumatism Association will  
 3 be presented by Dr. Orvaschel. This will be known as  
 4 exhibit 327 and the doctor will read from a statement  
 5 specially prepared for this purpose.

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 9 ---EXHIBIT NO. 327: Submission by the

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Dr. H.A. Orvaschel

Dr. Orvaschel: I am Dr. Orvaschel, and I am  
 and I am and gentleman of the Commission and this is  
 Dr. Orvaschel who is Chairman of the Health Committee of  
 the Canadian Rheumatism Association.

THE CHAIRMAN: Just to a chair,  
 please.

Dr. Orvaschel: The Canadian Rheumatism  
 Association is an organization composed of physicians  
 with a common interest in the better understanding,  
 treatment and prevention of arthritic and rheumatic  
 diseases. It has as its interest with a special interest  
 in the rheumatic diseases, research workers in the field  
 of arthritic diseases, family physicians, orthopedic surgeons  
 and specialists in physical medicine and rehabilitation.  
 The Association represents the majority of those physicians  
 who are engaged in the treatment of rheumatic diseases





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4 in Canada, and has done much to stimulate and guide the  
5 growth of research in the rheumatic diseases across the  
6 country. It has a close association with organizations  
7 having similar objectives in other countries.

8 The commoner forms of arthritis and  
9 the rheumatic diseases pose as a difficult problem. The  
10 causes of most of them remain unknown. Furthermore, once  
11 established, these afflictions usually persist in vary-  
12 ing degrees for the remainder of the patient's lifetime.  
13 However, the care of the arthritic patient cannot be  
14 divorced from a program to provide improved health care  
15 services to the chronically ill generally.

16 The Canadian Rheumatism Association  
17 believes that the chronic diseases in general, including  
18 the arthritic and rheumatic diseases, constitute one of  
19 the greatest challenges facing medicine today. It is  
20 anxious lest the special needs of these medically  
21 underprivileged patients be neglected, should the available  
22 resources be dissipated in providing for those who are  
23 better able to care for themselves. It is hoped that  
24 efforts to overcome the ravages of arthritis and the  
25 rheumatic diseases, as well as of the other chronic  
26 diseases, receive a very high priority in any recommended  
27 health program.

28 In its brief to the Commission, the  
29 Canadian Rheumatism Association has indicated certain  
30 deficiencies in the existing facilities for the diagnosis,  
prevention, treatment and rehabilitation of patients  
with arthritis and the rheumatic diseases. In the main  
these stem from a variety of factors including a shortage



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growth of research in the rheumatic diseases across the  
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The common theme of arthritis and  
the rheumatic diseases poses as a difficult problem. The  
causes of most of them remain unknown. Furthermore, once  
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The Canadian Rheumatism Association  
believes that the chronic diseases in general, including  
the arthritic and rheumatic diseases, constitute one of  
the greatest challenges facing medicine today. It is  
anxious to meet the special needs of these individuals  
and arthritic patients are neglected, should the available  
resources be directed in providing for those who are  
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In its quest to the rheumatism, the  
Canadian Rheumatism Association has initiated certain  
initiatives in the existing facilities for the diagnosis  
prevention, treatment and rehabilitation of patients  
with arthritis and the rheumatic diseases. In the area  
where there is a variety of services including a laboratory



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3 of hospital beds for patients with chronic diseases, a  
4 shortage and uneven distribution of medical consultants  
5 trained in the management of the rheumatic diseases, a  
6 shortage and uneven distribution of facilities essential  
7 for the prevention and correction of disability and  
8 deformity, such as physiotherapy, occupational therapy  
9 and rehabilitation services.

10 The advantages of providing concentra-  
11 ted treatment in segregated units, under the close  
12 supervision of specially trained teams, have been clearly  
13 demonstrated in certain hospitals of the Department of  
14 Veterans Affairs, and more recently in special rheumatic  
15 disease units sponsored by the Canadian Arthritis and  
16 Rheumatism Society in affiliation with the regional  
17 university departments of medicine, as has also been  
18 demonstrated in other countries, such as Britain, Sweden  
19 and elsewhere.

#### 20 Recommendations

21 The Canadian Rheumatism Association  
22 wishes to make two major recommendations to the government  
23 through the Royal Commission on Health Services:

- 24 (i) That rheumatic disease units be established  
25 for the investigation and treatment of  
26 patients with rheumatic diseases, located  
27 in relation to major general hospitals.  
28 (ii) That governmental support for research in  
29 arthritis and the rheumatic diseases be  
30 substantially increased over present  
levels.

The Canadian Rheumatism Association





of hospital beds for patients with chronic diseases, a shortage and uneven distribution of medical consultants trained in the management of the rheumatic diseases, a shortage and uneven distribution of facilities essential for the prevention and control of disability and deformity, such as physiotherapy, occupational therapy and rehabilitation services.

The advantages of providing concentrated treatment in segregated units, under the close supervision of specially trained staff, have been clearly demonstrated in certain hospitals of the Department of Veterans Affairs, and more recently in special rheumatic disease units sponsored by the Canadian Institutes of Health Research in affiliation with the national university departments of medicine, as has also been demonstrated in other countries, such as Britain, Sweden and elsewhere.

The Canadian Rheumatism Society has been asked to take the major recommendations to the Government to form the Royal Commission on Health Services.

- (i) That rheumatic diseases should be established as a separate category for the investigation and treatment of patients with rheumatic diseases, located in relation to major general hospitals.
- (ii) That governmental support for research in arthritis and the rheumatic diseases be substantially increased over present



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therefore urges the following program as a means of improving existing health facilities in the field of arthritis and the rheumatic diseases:

- (i) The establishment of rheumatic disease units in appropriate major centres as we have mentioned.
- (ii) The improvement of undergraduate, continuing and post-graduate training of physicians and allied professionals in this field.
- (iii) The provision of travelling consultation services to areas of insufficient population density to support major medical centres.
- (iv) The removal of other geographic and economic obstacles to good diagnosis and treatment.
- (v) The expansion of support of research activities designed to improve knowledge of arthritis and rheumatic disease and ultimately leading to better prevention and treatment.

It is apparent that the implementation of this program will require co-operation from physicians, universities and lay foundations. The following recommendations are directed specifically toward government:

- (i) Financial support must be made available for the establishment and support of the rheumatic disease treatment units mentioned.
- (ii) Financial support must be provided generously for the expansion of medical research activities.
- (iii) Financial support must be provided







Ogryzlo

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for the construction of adequate hospital and out-patient treatment facilities, including occupational and physiotherapy.

(iv) Economic obstacles should be removed by the development of a health care plan which will provide for the prepayment of medical expenses, including those of out-patient diagnostic services, out patient physiotherapy and occupational therapy.

I might say sir this brief closely parallels and supplements the brief which you have previously heard from the Canadian Arthritis and Rheumatism Society which is the lay organization in the Association.

THE CHAIRMAN: Thank you very much Dr. Ogryzlo. Dr. Baltzan?

COMMISSIONER BALTZAN: Just listening to your summary some of these things occurred to me requiring some slight improvement in the understanding. "It is anxious ..." and I read on the first page, bottom of the first paragraph:

"It is anxious lest the special needs  
"of these medically underprivileged  
"patients be neglected...."

Do you choose to select them as a separate group as against so many others that may be underprivileged with other kinds of medical conditions?

DR. OGRYZLO: No sir. The present problem now is if you have two patients who require admission to the hospital, for example, one has a heart



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THE CHAIRMAN: Thank you very much Dr.

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of the first paragraph:

"It is anxious that the special needs

"of these medically underserved

Do you choose to select them as a separate group as

against so many others that may be underserved with

other kind of medical conditions.

DR. BARTMAN: No sir. The present

proposal is to have two patients who require

admission to the hospital, for example, one has a heart



Ogryzlo

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4 attack, the other has an acute onslaught of say  
5 rheumatorid arthritis. The patient with the heart  
6 attack gets into the hospital and the other patient  
7 does not.

8 Our present circumstances do not  
9 recognize that this is just as important a situation as  
10 the person with the heart illness. This is what we  
11 are concerned with, that this not be allowed to develop.

12 In any health plan that is evolved,  
13 that these people be given their essential place and  
14 possibly even priority because these are long term  
15 illnesses, long time illnesses and once a patient  
16 becomes disabled, he becomes an economic liability for  
17 many years. Not for just a short time and if we do not  
18 recognize this, we really are economically losing rather  
19 than gaining.

20 COMMISSIONER BALTZAN: Actually you  
21 mean you choose not to have a long deferment of those  
22 cases. Have them privileged to enter the hospital  
23 rather than say given equivalent standing for an acute  
24 heart attack case?

25 DR. OGRYZLO: Long deferment is one,  
26 and of course as has been mentioned in our brief, existing  
27 facilities available for treatment for these do not  
28 exist in many places at all now.

29 COMMISSIONER GIRARD: What proportion  
30 of these patients could be treated with home care plans?  
We have heard a lot about that and I think this is the  
kind of patient that could very well lend itself to home  
care plans.





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COMMITTEE ON RHEUMATISM: Actually you  
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DR. BROWN: Long deferment is one,  
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DR. SMYTHE: This question leads into what I was going to say to the first one. A great deal of medical care of the patient with chronic diseases generally and arthritic diseases in particular can be done on an out-patient basis, or with home care plans.

They run into particular difficulties at the present time because many of the present pre-insurance schemes do not allow for out-patient treatments. Do not make sufficient allowance for out-patient diagnostic services. They are handicapped. They have other difficulty in terms of needing at least partial help at home.

Perhaps better treatment can be made available for them. Such help is not either available now or is available only through certain lay foundations in certain selected areas.



Dr. P. J. ... This question leads into

what I was going to say to the first one. A great deal

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in certain selected areas.





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THE CHAIRMAN: In this same context here, the paragraph which Dr. Baltzan referred you to, I don't know if I can just phrase this quite as well as I would like to, but the idea is this. There is a clamor of a kind for extended health services, and the accent from those who speak the loudest, shall we say, appears to be on the providing of physician services to the average man, just to the householder and the workman, from day to day, day calls, night calls, office calls, and so forth and etcetera.

Do I sense in your brief a feeling that some phases of this demand for physician services are likely to submerge what you think is a much more important segment?

DR. OGRYZLO: Yes, quite, sir.

DR. SMYTHE: That is exactly the thought we had in mind.

THE CHAIRMAN: We get this same notion coming from the mental health people, and those suffering from heart disease and so on, that the areas which we really should be concerning ourselves with now ought to be these areas that are more difficult to manage and to face up to.

DR. SMYTHE: Yes.

DR. OGRYZLO: This is exactly what we had in mind, sir, and the whole problem of health services, or health care, is much more than just the physicians' services, which is what most people are clamoring about now. This is only one small portion of the overall picture.



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THE CHAIRMAN: In this same context

I don't know if I can just phrase this quite as well as  
I would like to, but the idea is this. There is a  
claim of a kind for extended health services, and the  
accent from those who speak the loudest, shall we say,  
appears to be on the providing of physician services to  
the average man, just to the householder and the workman,  
from day to day, day calls, night calls, office calls,  
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Now I sense in your brief a feeling that  
some phases of this demand for physician services are  
likely to supersede what you think is a much more important  
DR. SMITH: That is exactly the thought

we had in mind.

THE CHAIRMAN: We get this same notion  
coming from the mental health people, and those coming  
from heart disease and so on, that the areas which we  
really should be concentrating ourselves with now ought to  
be those areas that are more difficult to manage and to  
lead up to.

DR. CORRY: This is exactly what we  
had in mind, sir, and the whole problem of health services  
of health care, is much more than just the physicians'  
services, which is what most people are concerned about  
now. This is only the small portion of the overall  
picture.



Ogryzlo 11557

In answer to Miss Girard's question with regard to home care, I think we would just have to give a rough estimate possibly, but it would be fair to say that certainly 50 to 70% of patients with this disease could be cared for at home. But a smaller group, 20 to 30%, who are seriously ill, and this disease does make people seriously ill and it can result in loss of life too. They cannot be treated anywhere else but in hospital, not just general hospitals, but hospitals with specialized equipment and specialized facilities. There would be very few hospitals in the Province of Ontario capable of handling this.

COMMISSIONER GIRARD: Even under this percentage?

DR. OGRYZLO: We cannot get them in either.

COMMISSIONER GIRARD: But couldn't they go home earlier if you had the facilities at home?

DR. OGRYZLO: Yes.

COMMISSIONER GIRARD: And among the 40%, maybe half of them could go back earlier if you had the facilities at home?

DR. OGRYZLO: Yes, this is the whole problem of rehabilitation.

DR. SMYTHE: The average stay is 35 days, so even in that group admitted to the hospital they require home care before entering and after discharge. The rest of the illness has to be managed by the family physician, with the resources available to him, which include all the treatment facilities necessary for home care.





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... answer to Miss Givens's question  
with regard to home care, I think we would just have to  
give a rough estimate positively, but it would be fair to  
say that certainly 50 to 60 of patients with this disease  
could be cared for at home. But a smaller group, 20 to  
30, could not be cared for at home. These are the people  
who are seriously ill and it can result in loss of life  
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then go home earlier if you had the facilities at home?  
DR. COLYND: Yes.  
DR. GIVENS: And among the  
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DR. COLYND: Yes, this is the whole

... of rehabilitation.  
DR. GIVENS: The average stay is 30  
days, so even in that group admitted to the hospital they  
would not come before entering the after discharge.  
The rest of the illness has to be managed by the family  
... with the resources available to him, which  
includes all the medical facilities necessary for home



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COMMISSONER VAN WART: On the other side of the picture, it may entail the taking of a daughter, or mother, or someone out of the productive market to have to stay at home and take care of this individual, and economically you haven't accomplished what you are trying to accomplish.

DR. SMYTHE: I think it is to get these people back to a productive life, which is the running of their own household.

COMMISSIONER VAN WART: I was thinking more of the person who would have to be taken from the labour market to take care of this person you are sending home early.

DR. OGRYZLO: Sending home early if they are not self-reliant.

COMMISSIONER VAN WART: Miss Girard's question was that you are taking them out of the hospital to save hospital costs, and continue treatment at home.

DR. SMYTHE: The Ontario Rheumatic Society has provided home service which we find very expensive, and we like to reserve it for patients where alternatives are not satisfactory.

COMMISSIONER VAN WART: Would you be in favour of having in connection with your acute general hospitals a chronic wing, which would take care of these until they can go home?

DR. OGRYZLO: We would not want just a chronic wing. It should be a rheumatic disease unit, because these patients pose special problems. Therefore, they should be kept segregated as a group, and the services



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COMMISSIONER VAN WART: Would you be  
in favour of having in connection with your acute General  
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DR. SMYTH: We would not want just a  
chronic wing, it should be a psychiatric disease unit.  
...they should be kept segregated as a group, and the services





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we have discussed should evolve around this centre. It could be part of a chronic wing.

COMMISSIONER VAN WART: And maintenance would not be as expensive as in an acute general hospital?

DR. OGRYZLO: That is right.

COMMISSIONER BALTZAN: These rheumatic disease units you recommend, as I see it, are a combination of two things, of accommodation and treatment of the acute and sub-acute conditions of arthritis, and research in connection with the treatment and causes of arthritis?

DR. OGRYZLO: We have in our brief recommended something of the order of between 25 and 30 units, based on the estimate that units would be roughly around 30 beds in size, on the basis of the population, one bed for arthritis for 0.055 beds per thousand population, which would give roughly between 1,000 and 1,500 beds across the country.

We envisage that those units, which would be located in relation to university centres, would be the major units, and would undertake the major task of basic and more difficult research, and that units should be provided in outlying centres, but comprehensive research might not be undertaken there. But both these types should be prepared to undertake a basic treatment program, so the only point about it is the two types you referred to, the ones involved in extensive research would be in university centres.

COMMISSIONER BALTZAN: Or teaching hospitals?

DR. OGRYZLO: Yes.



we have discussed should involve around this country. It could be part of a chronic wing.

COMMISSIONER: That is right. That is right.

COMMISSIONER: These rheumatic diseases units you recommend, as I see it, are a combination of two things, of accommodation and treatment of the acute and sub-acute conditions of arthritis, and research in connection with the treatment and causes of arthritis.

recommended something of the order of between 25 and 30 units, based on the estimate that units would be roughly around 30 beds in size, on the basis of the population, one bed for arthritis for 0.055 beds per thousand population, which would give roughly between 1,000 and 1,500 beds across the country.

We envisage that those units, which would be located in relation to university centres, would be the major units, and would undertake the major task of basic and more difficult research, and that units should be provided in outlying centres, but comprehensive research might not be undertaken there. But both these types should be prepared to undertake a basic treatment program, so the only point about it is the two types you referred to, the ones involved in extensive research would be in university centres.

COMMISSIONER: That is right.



Smythe 11560

COMMISSIONER BALTZAN: To overcome the present situation, you also indicate that there are specially trained teams. I suppose these are visiting teams, that go out to different areas, and you have special rheumatic disease units which will be in charge of, I think the new term is rheumatologist. I am speaking more of the specially trained teams. Are they a travelling group and available for consultation and teaching in areas where you cannot have units of the kind you envision?

DR. SMYTHE: That is correct. In some provinces, particularly in British Columbia, they have a team of travelling consultants. Consultation is available in major centres, but in any outlying areas the patients are not readily transportable because of their disease, and it is more convenient to have a travelling consultant go out at regular intervals and give advice to the local physicians on the best way of solving the problem. It might be wise to attach them to the units in the major centres if the unit provides consultation services for the whole area.

COMMISSIONER BALTZAN: We are talking about the team now.

DR. SMYTHE: With the rheumatologist would go, if necessary, an expert in physical medicine to advise on the setup of the physiotherapy department in the local hospital, a physiotherapist would go to provide ---- actually there usually has to be a resident physiotherapist there. It is usually a social worker goes with the team.

DR. OGRYZLO: The term team would apply more to the units themselves, which would involve a number





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the whole area.

About the team now.

DR. BROWN: With the rheumatologist

would go, if necessary, an expert in physical medicine to

advise on the care of the physiotherapy department in the

hospital, a dietitian would go to provide

advice on the care of the diet and physiotherapy

department. It is a team that goes with the team.

DR. BROWN: The team from which they

are to the various themselves, which would involve a number



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of rheumatologists, orthopaedic people, experts in physical medicine and physiotherapy, rehabilitation and social workers, so that a patient would have the services of them all. They do not all travel, only selected individuals would go out travelling.

COMMISSIONER BALTZAN: That is to meet the areas in the fringes, where they cannot be located in one of these central areas, where you advocate these central units. You are already sponsoring things like that?

DR. SMYTHE: The Canadian Arthritis and Rheumatism Society has sponsored this. Not the Medical Association.

COMMISSIONER VAN WART: Isn't one of the most important things with the team the educational program that goes along with them?

DR. OGRYZLO: That is right. Lay education on a broad front is left to the lay group, which is the Canadian Arthritis and Rheumatism Society. We attempt to educate the lay public and our own patients as we come into contact with them.

COMMISSIONER VAN WART: You supplement the lay program?

DR. OGRYZLO: Yes, most of the people in this Association are also on the Canadian Arthritis Society.

COMMISSIONER BALTZAN: What is your association with the Canadian Rheumatism Society?

DR. OGRYZLO: The Association is composed mainly of physicians. The Canadian Arthritis



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Ogryzlo 11562

and Rheumatism Society is largely a lay group, but they have medical advisory boards, which come largely from this Association.

COMMISSIONER BALTZAN: You speak of financial support must be provided generally for the expansion of medical research and elsewhere also treatment particularly for the under-privileged. That support would go to which of the two organizations then, I mean the contributions?



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4 DR. OGRYZLO: Oh, well, the only  
5 medical research for arthritis or rheumatic diseases --

6 THE CHAIRMAN: Would it be necessary  
7 to go to either?

8 DR. OGRYZLO: No. At the present time  
9 the sources are the Canadian Arthritis and Rheumatism  
10 Society and the Department of National Health. Those  
11 are the two major sources. They are handled by their  
12 own groups and the money doesn't have to be -- the  
13 Department of National Health and Welfare make use of  
14 the Canadian Arthritis and Rheumatism Society, medical  
15 boards and committees, to submit application for the  
16 spending of the money, but they handle the money  
17 themselves.

18 COMMISSIONER BALTZAN: And designate  
19 the areas the money should go to?

20 DR. OGRYZLO: That is right.

21 COMMISSIONER BALTZAN: And it must  
22 be approved by --

23 DR. OGRYZLO: I believe they have  
24 their own committee, but the committee seeks advice  
25 from the Arthritic and Rheumatism Society, and I suppose  
26 the reason is to avoid duplication. I am not sure what  
27 the National Health and Welfare -- I think there are only  
28 two people in it and they don't have much experience in  
29 arthritis and rheumatism.

30 COMMISSIONER BALTZAN: You speak about  
improving undergraduate and postgraduate and allied  
professions in this field. Is this now considered or is  
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Ogryzlo

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4 DR. SMYTHE: There are chairs in  
5 rheumatology in some of the British universities. The  
6 tradition in this country is to treat them, call them  
7 internists. I believe, in fact, there is no formal  
8 chair or section of rheumatology, they are all included  
9 in the internist, but they are known informally as  
rheumatologists.

10 COMMISSIONER BALTZAN: And you would  
11 advocate that there should be such a specialty in itself?

12 DR. SMYTHE: We think it is important  
13 it is not divorced from the mainstream of internal  
14 medicine, that these patients who are ill should have  
15 the skill and knowledge of the heart, endocrinist, so  
16 they have all their degrees in internal medicine first  
17 and then it becomes not important to put a further label  
on them.

18 DR. OGRYZLO: We would prefer to be  
19 just like the heart, cardiologist, neurologist, and all  
20 those. In the sense you speak about a neurologist,  
21 cardiologist, you can also speak of a rheumatologist,  
22 but there are no departments which are separate from  
23 internal medicine in Canada under the head of rheumatology  
24 as there is in Great Britain and Europe. The nearest  
25 is in the University of British Columbia, there is a  
section in rheumatology under The Department of Medicine.

26 THE CHAIRMAN: You don't want it, and  
27 if you did want it it wouldn't be in our power to give  
it to you.

28 DR. OGRYZLO: No.

29 COMMISSIONER BALTZAN: It is a matter  
30

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Ogryzlo

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for internal professional approach to the problem?

DR. OGRYZLO: Yes.

COMMISSIONER BALTZAN: Not for any  
outside body to enter into it.

DR. OGRYZLO: Our main concern, ladies  
and gentlemen, is that the people with rheumatic diseases  
are not forgotten.

THE CHAIRMAN: It is really the crux  
of your whole submission, and I think it is an extremely  
important one, and you can have our assurance it won't  
be forgotten.

THE SECRETARY: Mr. Chairman, the next  
submission is that of Dr. Mahoney, and it will be known  
as exhibit 328.

---EXHIBIT NO. 328: Submission of Dr. Leo J.  
Mahoney.



for internal professional purposes to the plan

COMMITTEE ON THE LAW: Not for the

outside how to enter into it.

Dr. COWLEY: Our main concern, ladies

and gentlemen, is that the people with pneumatic cases  
are not forgotten.

THE CHAIRMAN: It is really a case

of your whole submission, and I think it is an extremely  
important one, and you can have our assurance it won't  
be forgotten.

THE SECRETARY: Mr. Chairman, the next

submission is that of Mr. Mahoney, and it will be known  
as exhibit 118.

Submission of Mr. Mahoney.

---EXHIBIT 118.



SUBMISSION OF  
DR. LEO J. MAHONEY

APPEARANCE: Dr. Leo J. Mahoney

THE CHAIRMAN: Dr. Mahoney?

DR. MAHONEY: Yes, sir. Mr. Chairman and Members of the Royal Commission, I would like to express my appreciation of being allowed to come here and present this brief. The brief is not very long, and it deals with principles, principles which involve the treatment of a sick person by a doctor. But first I would like to read, in keeping with the dignity of the primary responsibility of a man providing for his own daily upkeep and that of his family.

This principle has been such an integral part of the development of democracy for almost 2,000 years, that we who comprised most affluent to society in history, tend no longer to appreciate it. It ensures a personal active participation in choosing or selecting a good service, and in paying for it. If it is not respected in relation to man's daily upkeep or subsistence and that of his family (food, clothing, housing) there is danger of political tyranny. The establishment of the Chinese Communes is obviously based on a denial of this fundamental right. It is in respect of this principle that measures taken to alleviate the financial burden of daily subsistence are in the forms of subsidies -- never the complete provision of free food, et cetera. When the State or any other organizations completely





MINUTES OF

Dr. L. J. Mahoney

April 1957

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 principle that we have taken to alleviate the financial  
 burden of daily necessities and in the form of subsidies  
 -- namely the complete provision of food, clothing, housing,  
 and other necessities.



Mahoney

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4 provides, it must of necessity completely control our  
5 fundamental human freedoms and rights go down the drain.

6 Primary responsibility presents a  
7 personal, active participation in the daily problems of  
8 life. When delegated to any organization -- which is  
9 almost always the state -- it becomes secondary and  
10 promotes an impersonal, lethargic, passive acceptance  
11 of what the State provides.

12 The right and duty of primary  
13 responsibility, besides being a protector against tyranny,  
14 is a good thing. "It involves many other fields." Its  
15 application to another completely different field to that  
16 under discussion will probably be our most potent weapon  
17 in the struggle between the ideologies of east and west  
18 for the uncommitted, underdeveloped countries of the  
19 world.

20 I would like to emphasize that a man  
21 can no more function properly to provide his daily  
22 subsistence if he is ill than if he is under-nourished  
23 and in adequately clothed. The service of a doctor for  
24 a sick individual is just as important as food and  
25 clothing, and the same principle of primary responsibility  
26 should be preserved. This principle should be respected  
27 when means to protect an individual from the possible  
28 crippling financial cost of illness -- medical insurance  
29 -- is being considered. Medical insurance should be  
30 provided in such a manner as to ensure a personal,  
active, individual participation in choosing each service  
and paying for it.

Thus schemes which embody third party



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active, individual participation in choosing each service  
and paying for it.

Thus solved, the responsibility must rest





Mahoney

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4 payments and closed service contracts violate this  
5 principle and will inevitably deleteriously affect the  
6 care of the sick individual by his doctor. This  
7 deterioration will occur the more quickly and drastically  
8 if such schemes are applied to the majority or all the  
9 individuals in society. Our present O.H.S.C. scheme  
10 is an example of such a plan which destroyed the  
11 principle of primary responsibility.

12 Although I did not deal with it in my  
13 brief, I would like to point out that the need for  
14 protection from the cost of illness varies with different  
15 individuals, different segments of society, and even in  
16 different geographical areas. A multiplicity of  
17 competing insurance companies with varying indemnity  
18 types of plans is necessary to satisfy the varying  
19 individual needs.

20 The second principle is that of  
21 Hippocrates, which I should like to restate: A doctor's  
22 overriding duty is to his patient. This means that he  
23 can never be under contract to any organization with the  
24 patients as the subject matter of the contract, or he  
25 will be unable to devote his full attention to the patient  
26 and his problem. The doctor's service is one which  
27 deals in life and death. If he is being subjected to  
28 some extraneous pressure, he cannot perform it properly.

29 All closed service arrangements, which  
30 include those sponsored by the medical profession, all  
closed panel clinics, violate the Hippocratic principle.

Doctors have always applied a means  
test and their fees have varied proportional to their



payments and closed service contracts violate this principle and will inevitably deteriorate, affect the care of the sick individual by his doctor. This deterioration will occur the more quickly and drastically if such schemes are applied to the majority of all the individuals in society. Our present O.H.S.C. scheme is an example of such a plan which destroyed the principle of primary responsibility.

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The second principle is that of reciprocity, which I should like to restate: A doctor's overriding duty is to his patient. This means that he can never be under contract to any organization with the patients as the subject matter of the contract, or he will be unable to devote his full attention to the patient and his problem. The doctor's service is one which ends in life and death. If he is being employed to some extraneous purpose, he cannot perform it properly.

All closed service arrangements, which include those sponsored by the medical profession, all closed panel clinics, violate the reciprocal principle. Doctors have always played a means and their fees have varied proportionally to their



Mahoney

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4 patients' ability to pay. Many have not been charged  
5 at all; some have been charged no more than the average.

6 Today our society has become so  
7 affluent that many people feel that such a means test  
8 is unnecessary and undesirable.

9 For this reason, the doctors should  
10 immediately make available to everyone their average  
11 fee for different services, so that the patient may  
12 properly exercise his right to actively choose and  
13 be responsible.

14 I have briefly outlined how a readily  
15 available, efficient mediation committee can function  
16 to protect the patient from over-charging if such should  
17 occur.

18 Finally, I have shown how economic  
19 advantages result from the preservation of solid funda-  
20 mental principles in medical insurance, and I have made  
21 a series of recommendations whereby the medical pro-  
22 fession may improve their service with respect to these  
23 principles.

24 I would also like to reiterate, that  
25 the present medical care provided to the people of  
26 Ontario and Canada by the doctors is as good as or  
27 better than any other in the world. There are numerous  
28 obvious defects which have been pointed out to you in  
29 some detail. These should be corrected, and can be,  
30 without destroying the principles which have already  
guided us to a level of medical care equal or above that  
of countries which have disregarded them. Contrary to  
what we have been told by some, a number of the State-run





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Mahoney

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4 medical schemes around the world do preserve this  
5 principle either completely or in part.

6 Let us not underrate ourselves. Rather,  
7 let us, as the leaders of the free world, correct the  
8 defects, preserve the principles and demonstrate to these  
9 countries that if they hope to achieve a level of medical  
10 care equal to ours, they must once again recognize some  
11 of the fundamental principles of democracy, which they  
12 have forgotten.

13 I have one correction to make. In  
14 item 24 I state that:

15 "The only country which attempted to  
16 "revoke a welfare measure was Belgium  
17 "and widespread rioting resulted."

18 A compulsory state-controlled medical scheme was intro-  
19 duced in Australia and was revoked four years later  
20 when the government was changed.

21 THE CHAIRMAN: Dr. Mahoney, without  
22 entering into any controversy with you over your statement  
23 of principles, I may have misunderstood you, but you  
24 can correct me, when you said that the intervention of  
25 any third party into any of these arrangements and the  
26 contractual or financial arrangements were bound to have  
27 a deleterious affect upon the quality of the service.  
28 I mean, is that putting it the way you put it? Am I  
29 saying the same thing as you said?

30 DR. MAHONEY: I consider that the third  
party arrangement violates this principle of primary  
responsibility.



medical schools around the world to preserve this

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duced in Australia and was revoked four years later  
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THE CHAIRMAN: Dr. Kennedy, without

so come into any controversy with you over your statement  
of principles, I now have reintroduced you, but you  
can correct me, when you said that the intervention of  
any third party into any of these human rights, and the  
contraction of financial arrangements were found to have  
a role which was not the result of the service.  
I mean, is that correct? The way we put it. Am I

asking the same thing as you said?

Dr. Kennedy: I am not sure that the same

thing is meant and whether this principle of

is correct.





Mahoney

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4 THE CHAIRMAN: By that are we to  
5 understand that you think the P.S.I. in Ontario to the  
6 extent to which it is used is violating one of these  
7 principles that you are upholding here this morning?

8 DR. MAHONEY: Yes, not only from the  
9 standpoint of the short period but from the standpoint  
10 that it is a service agreement.

11 THE CHAIRMAN: Would you tell us just  
12 why in what respect it does those things? P.S.I. has  
13 been presented to us as being something really pretty  
14 good and fully supported by those who participate in  
15 it, the vast majority of the physicians of Ontario.

16 DR. MAHONEY: As briefly as possible,  
17 the situation is that in any such organization the  
18 element of control more and more passes to the organiza-  
19 tion which runs it. This control affects the patient  
20 and the doctor and the services which he provides.  
21 Would you like to really know what I think is the most  
22 important problem on a service contract? I think the  
23 most prominent problem is over-utilization.

24 THE CHAIRMAN: Now, what is your view  
25 of prepayment to cover health services or, perhaps,  
26 take in a more limited field of medical service?

27 DR. MAHONEY: I have mentioned that  
28 P.S.I. has a plan which I consider to be ideal and that  
29 is a plan where a doctor has not signed a contract with  
30 P.S.I. His patients are covered for this insurance  
scheme but the patient pays the doctor and collects  
his money from the insurance scheme.

The patient and doctor deal strictly



THE CHAIRMAN: Now that we are to

discuss the question of the I.S.I. in Ontario to the extent to which it is used in violating one of these principles that you are upholding here this morning?

DR. HADFIELD: Yes, not only from the standpoint of the short period but from the standpoint that it is a service agreement.

THE CHAIRMAN: Would you tell us just why in your respect it does those things? I.S.I. has been presented to us as being something really pretty good and fully supported by those who participate in it, the vast majority of the physicians of Ontario.

DR. HADFIELD: As briefly as possible,

the situation is that in any such organization the element of control more and more passes to the organization which runs it. The control affects the patient and the doctor and the services which he provides. Would you like to really know what I think is the most important problem on a service contract? I think the most important problem is over-utilization.

THE CHAIRMAN: Now, what is your view

of payment to cover health services or, rather,

the in a more limited field of medical services?

DR. HADFIELD: I have mentioned that

I.S.I. has a plan which I consider to be ideal and that in a plan where a doctor has not signed a contract with I.S.I. the patients are covered for this insurance. There but the patient pays the doctor and collects his money from the insurance company.

The doctor and doctor deal directly



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with one another as they always have but the patient is protected financially from the cost.

THE CHAIRMAN: But if the patient cannot pay?

DR. MAHONEY: If the patient cannot pay the doctor at the time?

THE CHAIRMAN: Yes; or at any time, he must pay and he cannot pay.

DR. MAHONEY: I do not know how this has been worked out. This principle has been conducted in Australia; the patient pays the doctor and then collects his money from the insurance company and from what we have been told, or able to find out, all the patients seem to be able to pay.

THE CHAIRMAN: Well now, what is your view or have you a view to express on how we can take care of indigents?

DR. MAHONEY: The indigent can be taken care of by a similar form of insurance which is subsidized. If they cannot afford to pay the premium for this insurance it should be subsidized.

COMMISSIONER BALTZAN: You use the term or the word control; this is within the context in relation to payment. You have no objection or you do not negate the element of control in relation to inter-professional actions.

THE CHAIRMAN: I think that very point was made that the control would come into the practice of medicine.

DR. MAHONEY: Well, the price has to be





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THE CHAIRMAN: I think that very point

was made that the control would come from the practice

itself.

DR. MAHONEY: Well, the time has to be



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paid.

COMMISSIONER BALTZAN: I mean the medical profession itself by its membership; you do not object to that?

DR. MAHONEY: You mean with respect to P.S.I.?

COMMISSIONER BALTZAN: No, I am taking it outside of that. My original question was: you are talking of control only in the context of payment for fees?

DR. MAHONEY: And the control that must result from that, not only on a doctor but the people.

COMMISSIONER BALTZAN: You still think that control, professional control, over the actions of members of the Association should be maintained by the Association, by the doctors?

DR. MAHONEY: Oh, yes, as it is at the present time.

COMMISSIONER BALTZAN: As it is at the present?

DR. MAHONEY: Oh, yes.

COMMISSIONER BALTZAN: As against the so-called free-wheeling, without having disciplinary action by the medical profession itself over its own membership?

DR. MAHONEY: In my recommendations I make a recommendation that if there is any tendency to free-wheel among some individual doctors that there should be an efficient mediation committee available.



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DR. MALONEY: Yes, yes, as it is at the

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DR. MALONEY: Oh, yes.

COMMISSIONER BARTMAN: As against the

so-called free-wheeling, without having disciplinary  
action by the medical profession itself over its own

DR. MALONEY: In my understanding,  
there is a responsibility that if there is any tendency to  
free-wheel among some of the doctors that there  
should be an official association to maintain





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A patient knows about this and he knows what he should be charged and may complain to this committee very quickly and they will deal with the members of their profession immediately.

In other words, I mean more control in that respect than there is now if it is necessary. Does that answer your question?

COMMISSIONER BALTZAN: You are still tying it up with payment but I had something else in mind.

DR. MAHONEY: I am sorry, I did not appreciate that.

COMMISSIONER McCUTCHEON: You said in the case of the indigent the State must intervene?

DR. MAHONEY: Yes, sir.

COMMISSIONER McCUTCHEON: Now, you refer to the State subsidizing or paying a premium and I gather generally from reading your brief that the type of prepayment that you consider appropriate is an indemnity plan rather than a service plan?

DR. MAHONEY: Yes, sir.

COMMISSIONER McCUTCHEON: Now, what comments would you make about the system that you have in Ontario today where the Department of Public Welfare enters into a contract with the Ontario Medical Association for the care of indigents? Does that fall, or come within the points that you object to or not?

DR. MAHONEY: Yes, sir, that follows the principle but that is something that has to be accepted; in any certain segments of society these



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mind.

MR. MAHONEY: I am sorry, I did not  
understand that.

COMMISSIONER BARTON: You said in  
the case of the indictment the State must intervene?  
MR. MAHONEY: Yes, sir.

COMMISSIONER BARTON: Now, you  
refer to the State, indicting or paying a premium and  
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an indemnity plan rather than a service plan?  
MR. MAHONEY: Yes, sir.

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in Ontario today, how the Department of Health is  
satisfying into a contract with the Ontario Medical Association  
that for the year of 1954-55, for 1955-56, for 1956-57,  
that is the period that you object to or not?  
MR. MAHONEY: Yes, sir, that follows  
the principle but that is something that has to be  
a certain amount of association to be



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arrangements will have to be made.

COMMISSIONER McCUTCHEON: In other words, you are prepared to accept as a necessary evil the extension of the welfare principle as it is now applied, public assistance and so on, extending that to the medical field? You are not saying that the only way the State must look after their physician services is by paying a premium to a carrier where there is indemnity insurance?

DR. MAHONEY: I am saying I am not sure that that would not be better but I am saying that I would think we would have to accept the fact there are some areas where that will not look after the people and in these special isolated areas arrangements that presently exist under the welfare plan would have to be accepted.

COMMISSIONER McCUTCHEON: Thank you.

THE CHAIRMAN: Dr. Mahoney, you make your position quite clear. The coming forward of individuals is something we are glad to see and particularly when you come forward to discuss what you believe to be fundamental principles which may or may not be able to be accepted universally as you yourself understand.

It is helpful to us to have the views of people such as you who have a position to put forward and will state it as clearly as you have in the brief. We thank you.

DR. MAHONEY: Are you interested at all in the hospitalization plan and how it has violated





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...people who as you have a position to put forward  
and will accept it as early as you have in the past.  
Thank you.

...the ...

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Mahoney

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the principles?

THE CHAIRMAN: If you want to take a few minutes to tell us, we are interested in it.

DR. MAHONEY: May I have about five or seven minutes? A hospital is an institution where facilities are provided for the care of the sick individual, facilities which are not available at the home or office. Daily upkeep or subsistence, food and heat is an essential component of the service provided by any active treatment hospital; a major component in convalescent homes and almost the total component in homes for the chronically ill.

Thus, the principle of primary responsibility should have been respected and preserved.

Closely interwoven with the primary responsibility is another fundamental principle that the family unit is the fundamental unit in our society. When the family unit begins to disintegrate, society degenerates. As life expectancy increases the responsibility of the care of the senior members of our society can be expected to weigh more and more on the individual family units. They require encouragement and if help is necessary then this is the level at which it should be applied; this is the field of home nursing services and home health care.

One further principle stems from primary responsibility and that is the principle of subsidiary, where the principle responsibility must be delegated to an organization such as the State; it should be delegated only up to the level necessary and



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few minutes to tell us, we are interested in it.

12. HALL: Now I have about five

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Obviously, however, with the primary

responsibility is another fundamental principle, that

the family unit is the fundamental unit in our society.

When the family unit begins to disintegrate, society

disintegrates. As the family unit disintegrates, the individual

loses the care of the family member, of our society

can no longer care for him and more and more on the individual

family unit. There is a great movement and it helps

to a great extent, is the level at which it should

be applied, that is the field of home nursing services

and home health care.

The family unit is the

primary responsibility and that is the principle

of the family unit, where the principle of responsibility must be

extended to an organization such as the State; it

should be extended only up to the level necessary and





Mahoney

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no further. The rigid control which inevitably results from higher and higher delegation becomes more and more remote from the actual situation is was designed to create.

The defects in the provision of unemployment insurance from the federal level to all the isolated areas, communities and individuals of Canada, is an example. Our troubles with the hospitalization scheme stem from a flagrant disregard of all three of these principles.

Primary responsibility, support of the family unit and subsidiary. Unfortunately, they have been handed to the family doctor who, theoretically, should have been helped in his work by the scheme. The result of pressures are being to affect his ability to perform his service properly. Not only is the doctor affected but I would say the sick individual who requires the facilities of an active treatment hospital is the one who suffers.

I will refer to only one specific problem: the older person who feels unwell or who is suffering from some chronic, if not serious, disease. The doctor requires help, the help of diagnostic services, in determining whether a patient is really ill, seriously ill, or not.

These services are expensive, x-rays and laboratory tests. The sick member of the family, if not critically ill, does require his meals brought to him, help to the bathroom and undoubtedly some medication which is often quite costly. All of this is



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Mahoney

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an inconvenience and an irritation and a burden to the family.

The patient knows these services are available and his relatives know these services are available at no added cost in hospital. The patients have been told that it is their right to go into hospital if it is necessary and they consider it is necessary. The family doctor, on his part, wants to ease the problem of his patient sympathetically and accurately. His judgment, which he has spent so many costly years in developing, is the only faculty which he uses to handle the problem.

How can he remain sympathetic and accurate when the man's relatives and friends drop by continually or 'phone him to ask the reason for him not being in the hospital? The patient is after him too and sometimes the patient's symptoms will be magnified seriously by the relatives and the pressure that is on.

When the patient is a father of four or five small children on a minimum salary, the doctor has an added burden of realizing the investigation which he is ordering is going to be even more of a financial strain. Contrary to the impression gained from the newspapers, the prime requisite in making a good doctor out of a student is not that he possess a heart of stone.





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Mahoney

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4 In this community the most widespread  
5 complaint with respect to hospitals is the waiting  
6 period for admission. In my hospital it extends 6 to  
7 8 weeks with an elective case. Two to three weeks for  
8 more urgent ones, such as a patient with a cancer.  
9 Critically ill people, of course, are always admitted  
10 at once.

11 As you might expect, one of the causes  
12 of our problem is the delay in the discharge of a  
13 steady number of these same senior and chronically ill  
14 citizens to convalescent or chronically ill hospitals  
15 because they either came from no family unit or the  
16 one from which they did come a multitude of problems  
17 have arisen which precludes their return.

18 Paradoxically, it's this 8-week delay  
19 in admission which, at present, helps the family doctor  
20 in his dilemma. Once this shortage is improved, which  
21 I hope it will be, the pressure on the doctor will  
22 increase. The family unit could have been supported in  
23 the exercise of its responsibility by visiting nursing  
24 service and homemaker service, which should have been  
25 included in our hospitalization scheme.

26 The problem of diagnostic services  
27 could have been covered by out-patient services in  
28 doctors' offices, covered by indemnity insurance which  
29 is much less expensive and still keep the patient  
30 functioning at home. Thank you.

THE CHAIRMAN: Thank you very much,  
Dr. Mahoney. We will rise now until 2 o'clock.

--- Luncheon adjournment.



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complaint with respect to hospitals is the waiting period for admission. In my hospital it extends 6 to 8 weeks with an elective case. Two to three weeks for more recent ones, such as a patient with a cancer. Critically ill people, of course, are always admitted

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in admission which, at present, helps the family doctor in his dilemma. Once this shortage is improved, which

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The problem of diagnostic services

could have been covered by out-patient services in doctors' offices, covered by indemnity insurance which is much less expensive and still keep the patient functioning at home. Thank you.

THE CHAIRMAN: Thank you very much.

Dr. Wilson: We will rise now until 2 o'clock.





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---Upon Resuming at two p.m.

THE SECRETARY: Mr. Chairman, the next submission is from the Health League of Canada. It will be known as Exhibit 329 and Dr. Bates will introduce his group to the Commission.

---EXHIBIT NO. 329: Submission of the Health League of Canada.

S U B M I S S I O N O F  
THE HEALTH LEAGUE OF CANADA

APPEARANCES:

DR. G. BATES,  
DR. J. BROWN,  
DR. DEADMAN,  
MISS M. FERRIS.

DR. BATES: Mr. Chairman and Members of the Commission, the members represented in the Health League of Canada will be Dr. John Brown beside me, Professor of Physiology and Hygiene in the University of Toronto. Dr. William Deadman, Chief Pathologist for the Province of Ontario, and Miss Mabel Ferris, Assistant Director of the Health League of Canada, in addition to myself.

Miss Ferris, will you read the brief.

MISS FERRIS: On behalf of the Health League of Canada, I would like to read the recommendations.

THE CHAIRMAN: Would you please keep your chair if you don't mind.

... out to ...



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MISS FERRIS: Thank you. Dr. Bates will take over the discussion, but I will just read this.

R E C O M M E N D A T I O N S

1. ~~added to the report~~ We recommend that the voluntary health societies should be given every opportunity and encouragement to promote education in the field of preventive medicine.

2. ~~added to the report~~ Some grants have been given to certain national health organizations annually for a number of years. We see no reason why the present National Health grants should not be used in part to promote additional education efforts by voluntary health associations.

3. ~~added to the report~~ Since there are only two Provinces with province-wide legislation for the compulsory pasteurization of milk an effort should be made to encourage legislation in all of the provinces.

4. ~~added to the report~~ The situation with reference to pasteurization of milk in rural Canada is far from satisfactory. No person appears to know accurately the amount of unpasteurized milk which is consumed in the various Provinces. This requires surveys to find out.

5. ~~added to the report~~ The question of fluoridation of water is a special case. Here, a Committee with the powers of a Royal Commission in Ontario, have endorsed fluoridation of water after sittings lasting over two years. The procedure has been endorsed by virtually every scientific society in North America and has the almost universal endorsement of the Medical, Dental and Public Health Professions. Neglect of this procedure has meant that perhaps the most wide-spread of all infections, namely





MISS HUBBARD: Thank you, Dr. Bates.  
will take over the discussion, but I will just read this.

THE COMMISSION ON THE STATE OF THE NATION

1. We recommend that the voluntary health societies should be given every opportunity and encouragement to promote education in the field of preventive health.
2. Some grants have been given to certain national health organizations annually for a number of years. We see no reason why the present National Health Grants should not be used in part to promote additional education efforts by voluntary health organizations.
3. Since there are only two Provinces with province-wide legislation for the compulsory notification of milk and meat should be made to encourage legislation in all of the provinces.
4. The situation with reference to the notification of milk in rural Canada is far from satisfactory. No person should be known as a carrier of tuberculosis with which he is concerned in the various Provinces. This requires curative to find out.
5. The question of fluoridation of water is a special case. Some, a Committee with the power of a Royal Commission in Ontario, have expressed a decision to water supply systems existing with the view of the procedure has been endorsed by virtually every health authority in North America and the latest international agreement of the Medical, Dental and Public Health Authorities. The fact of this procedure has been that the most wide-spread of all diseases, dental caries.



Ferris 11582

dental decay, has been dealt with in a most casual way. It is our opinion as expressed in our brief to the Morden Commission in Ontario that fluoridation of water as advised by health authorities throughout North America should be mandatory.

There is every precedence for such procedure in that chlorination of water is obligatory in all North American cities. Iodization of salt is effective throughout Canada by virtue of a Dominion Law and the fortification of bread is in pretty much the same category. We believe that fluoridation of communal water supplies as recommended by all health authorities is an essential in the promotion of the health of the Canadian people.

#### Health versus Welfare

One of the most significant statements attributed to the greatest of sociologists is that of Sidney and Beatrice Webb, who in their book, THE PREVENTION OF DESTITUTION, stated that "the greatest single cause of poverty is sickness." Therefore, if sickness could be diminished the need for health and welfare in general would be reduced in proportion. The tendency to put on drives for health and welfare, at one and the same time, seems to ignore the difference between the two objectives. Some people think that in the financing of voluntary organizations the two appeals should be separated and there may be some validity in this argument.

Certainly we submit that it is a very great mistake to finance organizations in the field of welfare by depriving health societies of the financing







Ferris 11583

which is essential if sickness and mortality rates are to be kept down.

Nothing in this brief is calculated to discredit the efforts of so-called welfare agencies nor to discredit the virtue of the parable of the Good Samaritan. Nevertheless it is a fact that if sufficient emphasis is placed on the prevention of sickness the demands on the part of the public who delight in playing the part of the Good Samaritan would be diminished. It should be also obvious that if sufficient emphasis is placed on the importance of preventive medicine, hospital beds would be cleared of persons suffering from maladies which fall within the field of prevention. The control of milk-borne disease by pasteurization of milk; diptheria prevention and syphilis control are excellent examples of the way in which hospital beds may be cleared--the principle is already established in the whole field of medicine and preventive medicine.

We submit that more attention should be paid to the financing of national associations for the promotion of health and that if present methods of raising money are detrimental to the interests of organizations in the field of pure prevention, then these methods should be studied with a view to making certain that no effort is spared to cut sickness and mortality rates. The suggestion is that this end may be achieved best in the long run by the educational efforts of organized voluntary health societies.

A vast number of efficient charities may be simply an indication of the fact that we have



which is essential if diseases are controlled, and to  
the best advantage.  
But we in this field are inclined to  
disregard the importance of the principle of the  
disease. It is a fact that if sufficient emphasis is  
placed on the prevention of diseases, the demand on the  
part of the public who delight in playing the part of the  
doctor, Pakistan would be diminished. It should be also  
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paid to the financing of national organizations for the  
promotion of health and that it is urgent method of raising  
money and devoting it to the interests of organizations in  
the field of public prevention, then those who are usually  
be studied with a view to making decisions that no effort is  
expended to our advantage and medical progress. The situation  
is that this can only be achieved if it is done by  
the educational efforts of organized voluntary groups.  
The vast number of voluntary organizations  
are active in the promotion of the health of the people.



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neglected to put sufficient power behind our drives to keep people healthy. Poverty and the need for charity run parallel to excessive sickness and mortality rates.

The Health League of Canada, as the Canadian Citizens' Committee of the World Health Organization

In 1952 the Health League of Canada was recognized by the World Health Organization as the Canadian Citizens' Committee and the opinion was expressed in Geneva that work similar to that of the Health League of Canada should be instituted in all of the 111 countries supporting the World Health Organization.

We submit that Citizens' Committees of the World Health Organization have both a national and international function.

It is obvious that in each of the 111 countries, mortality rates can best be lowered by intensive education, making it possible for governments to spend money in the field of prevention at home. The international function of a Citizens' Committee rests in a recognition of the fact that as no man can live to himself alone no country can live to itself alone. Therefore high sickness and mortality rates in Brazil, India or Africa have their repercussions in every country of the world.

Every effort should, therefore, be made to cooperate with international associations to the end that world mortality rates may be lowered and the spread of diseases from one country to another prevented.

Senator Hubert Humphrey of the United States Senate, a great leader in the field of international





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The Health League of Canada, 1952-1953

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every effort should, therefore, be  
 made to cooperate with international associations in the  
 and to work for mortality rates may be lowered and the  
 spread of diseases from one country to another prevented.  
 Senator Robert Murphy of the U.S. has  
 stated, "A great lesson in the field of international



Ferris 11585

health, has coined the phrase "world peace through world health". It is suggested here that not only are there vast areas where there is unnecessary communicable disease, a menace to the physical health of the world, but that the existence of vast areas of diseased, short-lived, ignorant, dissatisfied persons is a menace to world peace.

THE CHAIRMAN: Thank you, Miss Ferris. Would you care to expand further this idea that is carried forward in two or three of your recommendations of separating the health from the welfare organization, and particularly the drive for funds?

DR. BATES: Mr. Chairman, first of all, may I say that this Commission and the Government will be initiating this sort of thing, because in my opinion for world peace or for world health there is nothing more important than the field of preventive medicine.

I found it necessary to do a little propaganda to emphasize the importance of what I have got to say, so I undertook in March to develop dental trouble and I ended up in the hospital and that is why Miss Ferris is reading this brief today, because I am not able to read it.

I am improving and I can still play golf, but nevertheless I have to emphasize the fact that an infected tooth is a dangerous thing and it may cause blindness or even death and that is why we have emphasized the importance of fluoridation of water supplies which, in our opinion, an opinion which we share with the dental profession, the medical profession and all of the technical



World Health

Health, has called this process "world health through world health". It is suggested here that not only are there vast areas where there is unnecessary communicable disease, a menace to the physical health of the world, but that the existence of vast areas of disease, poverty, ignorance, dissatisfied persons is a menace to world peace.

THE CHAIRMAN: Thank you, Miss Torgie.

Could you come to expand further this idea that is carried forward in two or three of your recommendations of appointing the health from the welfare organization, and particularly the drive for funds?

DR. WATKINS: Mr. Chairman, first of all,

may I say that this commission and the Government will be initiating this sort of thing, because in my opinion for world peace or for world health there is nothing more important than the field of preventive medicine.

I found it necessary to do a little propaganda to emphasize the importance of what I have got to say, so I undertook in March to develop dental medicine and I ended up in the hospital and that is why Miss Torgie is reading this paper today, because I am not able to read it.

I am improving and I can still play golf, but nevertheless I have to emphasize the fact that an infected tooth is a dangerous thing, and it may cause blindness or even death and that is why we have emphasized the importance of fluoridation of water supplies which, in our opinion, is a solution which we have used in the dental profession and all of the dental...





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professions that the discovery of fluoridation of communal water supplies as a prevention of dental caries is one of the most important discoveries, certainly in the last several decades.

The resistance to it is ridiculous and it brings out -- you want me to stick to this health and welfare?

THE CHAIRMAN: No. You just keep on the way you are going. If you have any ideas to express, you go ahead and do it.

DR. BATES: Dr. Brown has put in health and welfare.

THE CHAIRMAN: That is all right.

DR. BATES: I want to give you a little history, if I may. This organization was created during the First War and it came about because some of us in the Army discovered that the problem of venereal disease was an extremely difficult thing. Nobody wanted to talk about it. Nobody wanted to do anything about it and so citizens in Montreal and in Hamilton, in Toronto and particularly in these cities, began to agitate. We did surveys and we discovered that in the Toronto General Hospital, for example, twelve per cent of the patients had syphilis.

We discovered that in Montreal General Hospital it was considerably higher. We found that in the Toronto Mental Institution out on Queen Street no less than 24% of all the male patients had general paralysis of the insane and had died. Since that time, by virtue of what I am going to describe to you there has been an



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water supplies as a prevention of mental carrier is one  
of the most important discoveries, certainly in the last  
several decades.

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and it brings out -- you want to stick to this health  
and welfare.

DR. CHAIRMAN: No, you just keep on  
the way you are going. If you have any ideas to express,  
you go ahead and do it.

DR. WATSON: Dr. Brown has put in health  
and welfare.

DR. CHAIRMAN: That is a right.  
R. BAKER: I want to give you a little

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about it. Nobody wanted to do anything about it and no  
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particularly in these cities, began to agitate. We did  
surveys and we discovered that in the Toronto General  
Hospital, for example, twelve per cent of the patients  
had syphilis.

We discovered that in Montreal General  
Hospital it was considerably higher. We found that in the  
Toronto Mental Hospital out of 1,000 there were 100 cases  
that two of all the male patients had general syphilis.  
The disease and had it. Since that time, by virtue  
of what I am going to describe to you there has been an



Bates 11587

improvement . If you go out to that same institution on Queen Street now, and this brings in the relationship between health and welfare, you will find that there is no general paralysis to the insane. Those people are alive and their wives are alive, and there are no dependent children left behind, other than those who died from natural causes. There are no more deaths in that hospital, a great hospital, as a result of the preventable illness which could have been prevented then.

Now, the saving to the social agencies of this City and this whole country are astronomical. I have often thought an accountant should be put to work to work it out in terms of hundreds of thousands or even millions of dollars in saved money and still more in the saving of human lives.

Well, after we had our facts, we went to the Ontario Government and we got them to appoint a Royal Commission and this Royal Commission made certain recommendations. One of the results was the Ontario Act for the Prevention of Venereal Disease which has been copied all over the world.

We found that we were forcing people to take treatment and the people had no money, so then the national aspect --- this thing started in Toronto. The national aspect was then brought to the front and we went to the Honourable N.W. Raoul who was then President of the Privy Council and asked him to see to it a national conference was called for the discussion of this problem, and one other problem, the establishment of a Federal Department of Health under a separate Minister.







Bates 11588

We succeeded. The conference was called on the 19th of May, 1919. People from all of the Provinces were there. Two results came from it. One was that grants were made, the first grants in the history of public health in Canada, grants amounting to \$200,000.00 on the part of the Dominion Government, an added two grants from the Provincial Government that made \$400,000.00 a year to be devoted to what could be done to cure this dreadful scourge.

There isn't time to describe these things. Most of us have forgotten how serious syphilis was. Syphilis was the great killer. It outranked tuberculosis, cancer and pneumonia, the next three causes of death. So the Provinces took the money; they began to establish clinics but they had no patients, so they said, "What do we do next?"

We said the thing that is necessary is a new voluntary association to do things that the Government is unwilling to do because syphilis was a very disagreeable term and although I was in the Army, when I was asked out to tea and asked what I was doing in the Army and I had to say I was an officer in control of venereal disease, I wanted to crawl under the table. That was the attitude towards syphilis towards the end of the First War.

Well, they established the organization and we started to do propaganda. We imported a moving picture and we showed that picture to 1,000,000 people.



1944

It was a very long time

before, on the 15th of May, 1944, I was told that

the two were wrong. The results were from the

One was a rat grantee with a rat grant in the

vicinity of the health in Canada, grants amounting to

\$200,000.00 on the part of the British Government, and

and two grants from the Provincial Government that

made \$100,000.00 a year to be devoted to what could be

"There isn't time to discuss these

things. Most of us have forgotten how serious dysentery

was. Dysentery was the great killer. It continued

epidemic, cancer and pneumonia, the next three causes

of death. So the Province took the money; they began

to establish clinics but they had no patients, so they

said, "Let us do nothing."

we said the thing that is necessary

is a new voluntary association to do things that the

Government is unwilling to do because expenditure was a

very dangerous thing and although I was in the Army,

when I was asked not to join in 1944, I was told

in the Army and I said, "I was an officer in the Army

and I was asked not to join in 1944, I was told

the next day.

Well, they established the organization

and it started to do good things. It started a moving

picture and we know that by 1945, 1946, 1947,

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Bates

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4 Immediately the clinics were full, and  
5 immediately the amount of syphilis began to fall, so  
6 that by the end of the second war in Toronto General  
7 Hospital, instead of 13% of all patients, it had fallen  
8 to a half of one per cent. It was not only general  
9 paralysis of the insane which disappeared, but all the  
10 other end results of syphilis. So much for the value  
11 of a voluntary association in the health field in the  
12 direction of diminishing social problems, because they  
13 were diminished to a very, very large extent.

14 Then we discovered that we found a  
15 technique, we found that by the use of the press,  
16 appealing to the clergy, appealing to the businessmen  
17 and every person. In other words by appealing to good-  
18 hearted mankind, that we could reduce disease rates, so  
19 the next thing we stumbled on was the problem of  
20 diptheria. In 1926 Ramon discovered that anti-toxin  
21 Ramon or toxoid, would prevent diptheria, but nobody  
22 was doing anything about it. In hospital by 1929 there  
23 were 1,022 cases of diptheria in one year, and there  
24 were 65 deaths, and the old isolation hospital for  
25 diptheria, with over 400 beds, was always full, so we  
26 proposed a campaign to inform people about diptheria,  
27 and very soon we got results.

28 We distributed literature in the  
29 churches. We created moving pictures. We did everything  
30 we could, and by 1934, instead of 1,022 cases, there were  
22 cases, and instead of 65 deaths, there were no deaths  
at all, and four years afterwards the isolation hospital  
was closed.



Immediately the clinics were full, and immediately the amount of supplies began to fall, so that by the end of the second year in Toronto General Hospital, instead of 13% of all patients, it had fallen to a half of one per cent. It was not only general paralysis of the insane which disappeared, but all the other and milder of syphilis. So much for the value of a voluntary association in the health field in the direction of diminishing social problems, because they were diminished to a very, very large extent.

Then we discovered that we found a

technique, we found that by the use of the press, appealing to the clergy, appealing to the businessmen and every person. In other words by appealing to good-hearted mankind, that we could reduce disease rates, so the next thing we stumbled on was the problem of diphtheria. In 1926 Eaton discovered that anti-toxin serum or toxoid, would prevent diphtheria, but nobody was doing anything about it. In hospital by 1928 there were 1,012 cases of diphtheria in one year, and there were 25 deaths, and the old isolation hospital for diphtheria, with over 400 beds, was always full, so we proposed a campaign to inform people about diphtheria, and very soon we got results.

As distributed literature in the churches. We started giving pictures. We did everything we could, and by 1930, instead of 1,012 cases, there were 23 cases, and instead of 25 deaths, there were no deaths at all, and four years afterwards the isolation hospital



Bates

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4 I was in Paris last summer, and had  
5 tea again with Professor Ramon, and he said: "I am  
6 disgusted with France. In 1959 you had in Canada 39  
7 cases of diptheria and no deaths, and in France, where  
8 we invented toxoid and where we put a law on the  
9 statute book of the provinces, we had 41 deaths. What  
10 is the matter?" And I said: "Professor Ramon, you  
11 know just as well as I do you haven't got public opinion  
12 behind what you are trying to do", and so virtually there  
13 is an occasional sporadic outbreak where we are not  
14 quite as successful as we ought to be, but on the whole  
15 diptheria has disappeared, and that was known not as  
16 the killer of adults, but of children, and it has gone.

17 The next thing we came to was the  
18 problem of milk-borne disease. Mr. McCutcheon will  
19 remember this. We had a great health officer here, and  
20 we put his picture in the City Hall, and established the  
21 Hastings Scholarships in memory of that great man. This  
22 was told me by Alf McGuire, who said the gentleman came  
23 into him one day and said: "You are going to put a law  
24 of milk on the statute books of Toronto, and you are  
25 going to do it this year, and if you don't do it I will  
26 resign my job and fight you." Mr. McGuire said they were  
27 afraid of the old doctor, and put it on the books. The  
28 infant mortality rate fell by one-third in two years.  
29 That was in 1914, and that could be done by one devoted  
30 man, but there are not very many men of that sort, and  
we discovered that in the other parts of Canada this  
thing hadn't happened.

Then along came Mac Sheppard. So one





I was in Paris last summer, and had  
seen again with Professor Ranson, and he said: "I am  
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cases of diphtheria and no deaths, and in France, where  
we invented toxoid and where we put a law on the  
statute book of the provinces, we had 41 deaths. What  
is the matter?" And I said: "Professor Ranson, you  
know just as well as I do you haven't got public opinion  
behind what you're trying to do", and so virtually there  
is an occasional sporadic outbreak where we are not  
quite as successful as we ought to be, but on the whole  
diphtheria has disappeared, and that was known not as  
the killer of babies, but of children, and it has gone.  
The next thing we came to was the  
problem of milk-borne disease. Mr. Mountbatten will  
remember this. We had a great health officer here, and  
he put his picture in the City Hall, and established the  
National School of Hygiene in memory of that great man. This  
was told to me by Mr. Ranson, who said the gentleman came  
into his room one day and said: "You are going to put a law  
of milk on the statute books of Toronto, and you are  
going to do it this year, and if you don't do it I will  
resign my job and fight you." Mr. Ranson said they were  
afraid of the old doctor, and put it on the books. The  
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That was in 1915, and that could be done by one devoted  
man, but there are not very many men of that sort, and  
we discovered that in the other parts of Canada this  
thing hasn't happened.  
Then along came Macdonald, and



Bates

11591

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4 day I went down with Mr. Atkinson of the Star, with  
5 Sir James Wood and Mr. Bickel to Mr. Hepburn, and said  
6 "We want you to do the same thing for Ontario". He  
7 said: "I would be delighted, my dearest friend died  
8 of undulant fever only a month ago, but I want you to  
9 remember something. In spite of all that you tell me,  
10 I am a politician and I want to stay here". I said:  
11 "Well, suppose public opinion demanded pasteurization  
12 of milk? What then?" He said: "I would promise you a  
13 law the next day". I said "I have another proposal.  
14 Suppose we do your propaganda for you?" He said: "That  
15 is a bargain. It is delightful. What more can I do?"  
16 I said: "You can give us \$10,000.00 a year for propaganda"  
17 and he said: "All right, it is a bargain," and he gave  
18 it to us.

19  
20 We got the first large political area  
21 in the world to adopt a compulsory pasteurization, and  
22 the same thing happened in the Province of Ontario as  
23 in the City of Toronto. We then went to Mr. Duplessis  
24 with a large deputation from Montreal. We had already  
25 gone to Mr. Godfrey, who promised the legislation, but  
26 the government changed. We went to Mr. Duplessis with  
27 a mixture of Liberals and Conservatives. He gave us the  
28 same story, but not the law, and Quebec has not got a  
29 law yet. Then a law went through Saskatchewan, so that  
30 now there are two large political areas in Canada, where  
the pasteurization of milk is obligatory in a good many  
urban areas, but there are large rural areas in all of  
the provinces where milk is not pasteurized and there  
is still quite a lot of milk-borne disease because of that.



I went down to the... of the... with  
... and ... to ... and ...  
"I want you to do the same thing as ..."  
"I would like to ..."  
... only ... and I want you to  
... in ... of ... that you ...  
I said: "I want to stay here."  
"Well, ... opinion ..."  
... "What ...?" he said. "I would ..."  
I said: "I ..."  
... we do your ..."  
... "I ..."  
... "I ..."  
I said: "You can give us \$10,000 ..."  
... "All right, it is a ... and we have  
... to us.  
We got the first ...  
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... to the City of ... We then went to ...  
with a ... from Montreal. We had already  
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Bates

11592

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4 The solution is more propaganda. Well,  
5 from there we went on, and we found that it was necessary  
6 to establish a machinery of propaganda in the form of  
7 news reels in French and English, going to all Canadian  
8 provinces, and then the thing began to expand a little.  
9 I was working more and more in the Province of Quebec,  
10 and I found I had to learn French, and that is where I  
11 met Miss Girard in Paris two years ago, because this  
12 thing is international.

13 But we had stumbled one after another  
14 on a lot of other problems, and therefore one by one  
15 we took them up. Immunization. Yes, you have got to  
16 immunize against diphtheria, but also against polio. Our  
17 experience in polio here this last few weeks has not  
18 been entirely satisfactory. The new vaccine was only  
19 applied to the extent of about 25%. This is not good  
20 enough. I have seen some of the teeth.

21 Then there came in tetanus and whooping  
22 cough, and the other things, and they were placed under  
23 a Division, and without enough money we did our best  
24 to struggle with diphtheria and these other communicable  
25 diseases. We wanted to do something about child and  
26 maternal health, because we found that instead of being  
27 first amongst the nations as we might be, when it comes  
28 to mortality rates, Canada is thirteenth. It is not  
29 good enough.

30 The question of industrial health  
became important, because we found very rapidly that when  
a man is ill he cannot work. Now, if you want to get  
the most dramatic demonstration of that kind of thing,



The solution is more complicated. I feel  
from there we went on, and we found that it is necessary  
to establish a machinery of program, and in the form of  
new laws in French and English, going to all Canadian  
provinces, and then the time came to extend a little.  
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and I found I had to learn French, and that is where I  
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experience in public health has not  
been entirely satisfactory. The new machine was only  
applied to the extent of about 1950. This is not good

Then there came in between the whooping  
cough, and the other things, and they were placed under  
a division, and without enough money we had to pass  
to all the other diseases and these other communicable  
diseases. We wanted to do something about child and  
maternal health, because we found that instead of being  
first amongst the nations as we might be, when it comes  
to mortality rates, Canada is last. It is not  
good at all.

The question of maternal health  
became important, because we found very early that what  
a lot is still to be done. Now, if you want to see  
the most effective demonstration of that is in China,



Bates

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4 you have got to go to some of the so-called backward  
5 countries. We work with the World Health Organization  
6 in the problem of malaria control. In Burma it takes  
7 three men to do one man's work, because two out of three  
8 always have malaria, and we are trying to get organiza-  
9 tions like ours founded in Burma, and so on.

10 The question of nutrition is a problem  
11 which also occupies the attention of one of our divisions,  
12 but the latest bugaboo, the latest difficulty, has been  
13 the problem of fluoridation of communal water supplies.  
14 There is no doubt about it in my mind, that a dead tooth  
15 is a dangerous tooth, and an infected tooth is liable  
16 to kill you. Some of us have forgotten that the late  
17 Sam McBride died in the flower of his manhood two days  
18 after his teeth were extracted. The Chairman of one  
19 of our committees died in Sunnybrook Hospital from a  
20 disease which came from infected teeth.

21 The reason that infected teeth has  
22 been allowed to sneak into prominence has been penicillin.  
23 It is so easy to kill a thing with penicillin. Professor  
24 Ramon told me this in his house less than a year ago,  
25 that penicillin has become so conspicuous that many  
26 doctors are forgetting what immunity means. Now they  
27 don't talk about dental infection, but it is still there  
28 all the same.

29 Our argument is that death rates can  
30 be cut very, very materially. They have been cut since  
the beginning of this century, from an average of 50  
to 70, so that people die now at 70, instead of dying  
at 50.





You have got to go to some of the so-called backward countries. We work with the World Health Organization in the problem of malaria control. In some it takes three men to do one man's work, because two out of three always have malaria, and we are trying to get organizations like ours founded in Burma, and so on.

The question of malaria is a problem

which also occupies the attention of one of our divisions but the latest method, the latest technology, has been the problem of elimination of commercial water supplies. There is no doubt about it in my mind, that a dead tooth is a dangerous tooth, and an infected tooth is liable to kill you. Some of us have forgotten that the late Mr. McBride died in the flower of his manhood two days after his teeth were extracted. The Chairman of one of our committees died in a hospital because of a tooth which came from infected teeth.

The reason that infected teeth are been allowed to spread into prominence has been because it is so easy to kill a thing with penicillin. I have told me this in his house less than a year ago, that penicillin has become so conspicuous that many doctors are forgetting what immunity means. Now they don't talk about dental infection, but it is still there.

It is a fact that some nations can be very, very material. They have been the victims of this campaign, from an attitude of to do, or that, or to do, instead of doing it.



Bates

11594

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4 I talked this over with Paul Dudley  
5 White, who we had up here at the first National Health  
6 Forum in March. He and Mr. Borsch of Philadelphia have  
7 made the statement that if our present knowledge of  
8 preventive medicine could be applied it is very likely  
9 that by the end of this century the expectation of life,  
10 instead of being 70 as it is now, it may well be 100.  
11 I don't think that he was dreaming. I think he means  
12 it, because we are adding about half a year per year,  
13 and this will go on and on and on, creating new problems  
14 it is true, because that means that with a population  
15 which is increasingly aged we are getting into the area  
16 of where there are people who are dying who didn't die  
17 before because they are in that particular age area, and  
18 I am thinking particularly of heart disease and cancer.  
19 Heart disease and cancer disease rates have gone up  
20 very largely because people are growing older.

21 This then, with these other various  
22 problems with which we are concerned, means that we have  
23 got another problem that nobody ever thought of before,  
24 and that is the problem of what is called gerontology.  
25 Industry, geared to the statistics of 1900, are letting  
26 men out to pasture when they are 65, men who want to work  
27 and are able to work. We are putting up old peoples'  
28 homes for people who don't want old peoples' homes, and  
29 people who want to keep on, just as you and I in this  
30 room do. We don't want to stop, and that means that we  
have got to gear our ideas to new ideas, and one of  
them is a physical fitness program. We are playing  
with physical fitness in this country. I went out and



I talked this over with Sam Bodley  
White, who we had to have at the 1954 National Health  
Forum in London. He and Mr. Rosen of Philadelphia have  
made the statement that in our present knowledge of  
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and that is the problem of what is called gerontology.  
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us out to pasture when they are old, and we want to work  
and are able to work. We are putting up old people  
homes for people who don't want old people's homes, and  
people who want to keep on, just as we and I in this  
room do. We don't want to stop, and that means that we  
have got to keep our ideas on new ideas, and one of  
them is a physical fitness program. It was during  
with physical fitness in this country.





ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Bates

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played golf yesterday, and I feel an awful lot better  
for it. I would be even stupider than I am if I hadn't  
played golf yesterday.

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played golf yesterday, and I feel an awful lot better  
for it. I would be even stronger than I am if I hadn't  
played golf yesterday.



Bates

11596

BL/dpw

We have seen people - one of my friends, a friend of Mr. McCutcheon's, you will know him, died last Thursday. He was 58 and he weighed over 200 pounds, and if it were not for that I think he would be here today.

We have these problems of gerontology. Are we therefore going to continue to put up more and more buildings for people who are physically aged but mentally alert, or are we going to give them a great chance? I think industry is making a mistake. We have to work out ways and means.

Now, I have referred to the possibility of developing more initiative and helping voluntary associations who want to do something in the field of health. I think that, as we suggested in the brief, some place, somehow, money should be found to do the propaganda which is necessary to educate our people to keep fit for a much longer time, and I believe by so doing we are not only conserving their physical health but moral health as well.

A very famous Frenchman said 100 years ago, he made the statement that an American gets an idea and he gets a friend and three or four of them sit round a table and they form a committee and that committee is a voluntary association and people do what they want to do, they do it because they can do it themselves. But it seems to me that the voluntary association is the spirit of democracy.

Another man, Priestley, in the book, made the statement that community is the thing in which





We have seen people - one of the

friends, a friend of Mr. Woodhouse's, you will know

him, died last Thursday. He was 58 and he weighed

over 300 pounds, and if it were not for that I think

he would be here today.

We have these problems of gerontology.

And we therefore going to continue to put us more and

more buildings for people who are physically aged but

mentally alert, or are we going to give them a great

chance? I think industry is making a mistake. We

have to work out ways and means.

Now, I have referred to the possibility

of developing more initiative and helping voluntary

associations who want to do something in the field of

health. I think that, as we aggregate, in the field,

some place, somehow, money should be found to do the

propaganda which is necessary to educate our people

to keep fit for a much longer time, and I believe in

so doing we are not only conserving their physical

health but mental health as well.

A very famous Frenchman said 100 years

ago, he made the statement that an American gets in

love and he gets a friend and three or four of them

all round a table and they form a committee and that

committee is a voluntary association and people do what

they want to do, they do it because they can do it

themselves. But it seems to me that the voluntary

association is the spirit of democracy.

Another man, Webster, in the 19th

made the statement that democracy is the thing in which



Bates

11597

the greatest number of people assume unimposed obligations, and I think the more we do for people the more they want us to do for them.

I have seen this whole organization's finances falter. We are not doing the job in Toronto or anywhere else, because we have not the money to encourage the volunteer to come in and work his head off and get the job done.

DR. BROWN: Well, the only thing I would like to do is to reiterate what Gordon Bates said, that health is a person's responsibility, not his right; they should look after themselves. Government can provide means for them to do it, but they have to take the steps and do it for themselves.

COMMISSIONER BALTZAN: Dr. Bates, I have been most charmed with your verbal presentation, and judging from your own contribution, the work you have done, I seem to derive this: that persuasion apparently accomplishes more than legislation. Which brings me to one small question in relation to pasteurization.

So far it is compulsory in only two provinces. What is the bottleneck in the other areas?

DR. BATES: Indifference, politics. The two areas where I see politics stepping in very seriously are pasteurization and fluoridation. I called a Deputy Minister - I won't say which one. We were appealed to by the Federation of Mayors and Municipalities to advise them as to what to do about fluoridation of water. I immediately called a Deputy Minister - I won't



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Gates

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us to do for them.

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or anywhere else, because we have not the money to  
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off and get the job done.

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would like to do is to reiterate what Gordon Bates  
said, that health is a person's responsibility, not  
his right; they should look after themselves. Government  
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take the steps and do it for themselves.

COMMISSIONER BULLMAN: Mr. Bates, I  
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have done, I seem to derive this that presentation  
apparently accomplishes more than legislation which  
brings me to one small question in relation to pasteuriza-  
tion.

So far it is compulsory in only two  
provinces. What is the bottleneck in the other areas?  
MR. BATES: Indifference, politics.

The two areas where I see politics creeping in very  
seriously are pasteurization and chlorination. I called  
a Deputy Minister - I won't say which one, we were  
appealed to by the Federation of Women and Child Welfare  
to advise them as to what to do about fluoridation of  
water. I immediately called a Deputy Minister - I won't





Bates

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say who - and I said, "Will you give me your opinion as to fluoridation of water?" and his reply was, "You know damn well what my opinion is; it is the same as that of every health officer in North America." But he also said, "You know the opinion of my Minister, therefore I have no opinion."

COMMISSIONER BALTZAN: I read here, sir, your reference to Sydney and Beatrice Webb, that the greatest single cause of poverty is sickness. I wonder if that actually applies at this time; if one were to write that?

DR. BATES: I think so. I was in London about two years ago and Sir John Charles asked me to go to the Council of Health Education. He said, "I think perhaps you can get me out of a hole." I said, "What is it?" and he said, "The meeting is tomorrow in Grafton and my principal speaker has had a heart attack. Will you step in and do it?" I said, "I will probably say a lot of things you don't like, but I will do it." I quoted Beatrice Webb and some man got up in the corner and questioned it and I said, "If you had been in charge of the biggest clinic in Canada for years, if you had seen 200 people in one clinic and you knew a lot of them were going to die of cancer, you wouldn't say that", and I sat down.

Immediately, a black man from Africa got up and he said, "I support Dr. Bates in anything he says, and if you want proof come to Africa and I will show you."

There is a vast number of people who



say who - and I said, "Will you give me your opinion  
as to the character of the water?" and his reply was, "You  
know damn well what my opinion is; it is the same as  
that of every health officer in North America." But  
he also said, "You know the opinion of my minister,  
therefore I have no opinion."

CONTRIBUTOR: I read some,  
sir, your reference to Sydney and Bathurst, that  
the greatest single cause of poverty is sickness. I  
wonder if that actually applies at this time; it once  
was to me that?

H. WATKINS: I think so. I was in  
London about two years ago and Sir John Chadwick asked  
me to go to the Council of Health Education. He said,  
"I think perhaps you can get me out of a hole." I  
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tomorrow in Grafton and my principal speaker has had  
a heart attack. Will you step in and do it?" I said,  
"I will probably say a lot of things you don't want."

But I will do it. I quoted Bathurst's words and some ran  
out up in the corner and questioned it and I said, "If  
you had been in charge of the biggest clinic in Canada  
100 years, if you had seen 100 people in one clinic  
and you knew a lot of them were going to die of cancer,  
you wouldn't say that," and I sat down.

Immediately, a man from Africa  
got up and said, "I support Mr. Watkins in everything  
he says, and if you want, most come to this and I  
will show you."

There is a vast number of people...



Bates

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haven't got enough to eat, who are not now starving but who have diseases which we have never heard of before and they die.

I am inclined to agree with Rabbi Fineberg that the misery and the despondency and the destitution and despair of Africa might well lead to an atomic war.

THE CHAIRMAN: Well, Dr. Bates, that might well be true, but I am afraid that is outside the scope of this Commission. The question is what is relevant to Canada.

COMMISSIONER BALTZAN: Yes, it is within that context I ask, because following upon that, Dr. Bates, always we are hearing throughout the country the question coming up where social welfare benefits, that is the supply of basic needs, ends, and where sickness begins, and some of us are unable to say where that division comes along, and frequently those things belonging to social aid which keep sickness away are taken within the realm of services where they are actually social welfare services. Am I right?

DR. BATES: Well, of course, as soon as you cut sickness rates, which your social welfare - I think the basis of prosperity of a country depends on the ability to produce, and they can't produce if they are sick, and if they can't produce there must be the social aids to make up for the deficiency.

COMMISSIONER STRACHAN: I have no questions, Mr. Chairman, but I would like Dr. Bates to know I have personally followed his work and activities







Bates

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for the Health League of Canada through your magazine, "Health" and certainly appreciate all the efforts that he has performed in years gone by and I appreciate his dedication to this work.

THE CHAIRMAN: I think we would all join in that, Dr. Strachan.

COMMISSIONER STRACHAN: He has given us much valuable information in this brief.

DR. BATES: There is one thing I might add. I think something should be done to unscramble this confusion between health and welfare.

One thing I notice, and that is there appears to be no unity among health organizations. I think there must be a united front with the main objective to cutting sickness and death rates, and I think we have neglected it for a great variety of reasons which would require a long treatise to exploit. But I think something should be done to stabilize it.

We have been running on a ridiculously small budget, our staff is underpaid; we know they are not doing the job they should be doing. Whose fault it is I am not prepared to say publicly at this moment but I think more attention must be paid to make it possible to create more and more enthusiasm among men and women in the business world as well as the professional world.

Last year I had a long talk with Sir Cecil Wakeley appropos the mental services. I said to him, "I understand that the profession are not particularly satisfied with the national health scheme." He said, "Well, there are a lot of us who are not



for the health. I think it is important to have a  
"health" and certainly, experience all the efforts to  
be performed in your name and I appreciate his  
dedication to this work.

THE HEALTH. I think the world will

join in that, Dr. Johnson.

COMMISSIONER: I think he has given

us much valuable information in this order.

DR. BATES: There is one thing I might

add. I think something should be done to improve

this confusion between health and welfare.

One thing I noticed, and that is there

appears to be no unity among health organizations.

I think there must be a united front with the health

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We have been running on a relatively

small budget, our staff is small and we know they are

not doing the job they should be doing. Those facts it

is I am not prepared to say publicly at this moment but

I think more attention must be paid to make it possible

to create more and more emphasis among men and women

in the business world as well as the professional world

that health is a very important thing.

well we may approach the mental services. I am not

sure, "I understand that the profession are not satis-

factory satisfied with the national health service."

He said, "Well, there was a lot of discussion about





Bates

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3 satisfied." I said, "Did it ever strike you that it is  
4 your own fault, if you are becoming civil servants and  
5 you don't want to be?" He said, "What do you mean?"  
6 I said, "You have, in the British Medical Association,  
7 a system of medical ethics. If you give a television  
8 address, if your picture appears in the paper, if you  
9 do anything to attract attention to yourself in the  
10 field of health, you are likely to be called before  
11 the Discipline Committee and thrown out. Is that true?"  
12 He said, "Yes." I said, "In other words, you have  
13 managed very successfully to persuade the British  
14 people that your own Medical Association prevents you  
15 from what the British public considers is doing your  
16 job, that is educating the British people to keep  
17 healthy?"

18 It is all right leaving it to the  
19 public health officer, but what is the individual doing?  
20 Not anything like what he should be doing. Dr. Paul  
21 Dudley White, two or three years ago, did a good job  
22 and he said that if we are going to live longer you  
23 have got to get physical education yourself. "I would  
24 advise all you fellows to leave your cars at home", he  
25 said, "climb stairs instead of taking the elevator,  
26 preach the doctrine of physical fitness and that will  
27 make you live longer."

28 That applies to all of us. I don't  
29 think there is enough health education. Governments  
30 try to do health education and do it very badly, and  
tradition has prevented in the past all the health  
education we should be doing.



...I said, "Don't ever strike me that it is  
your own fault, if you are becoming ill, it is because you  
don't want to be," he said, "What do you mean?"  
I said, "You have, in the British Medical Association,  
a system of medical ethics. If you give a television  
address, if your picture appears in the paper, if you  
do anything to attract attention to yourself in the  
field of health, you are likely to be called before  
the Discipline Committee and thrown out. Is that true?"  
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managed very successfully to persuade the British  
people that your own Medical Association prevents you  
from what the British public considers as being your  
job, that is educating the British people to keep  
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and he said that he was going to live longer you  
have got to get physical education yourself. "I would  
advise all you fellows to leave your cars at home", he  
said, "climb stairs instead of taking the elevator,  
break the routine of physical fitness and that will  
take you five longer."  
That applies to all of us. I don't  
think there is enough health education. Government  
say to us health education and do it very badly, and  
in addition, as prevention in the past all the health  
education we are doing.



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TORONTO, ONTARIO

Bates

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THE CHAIRMAN: Thank you very much,  
Dr. Bates and your group. The ideas that you have  
put forward in the brief will be studied and the very  
sincere discussion from the long experience of Dr.  
Bates will be very valuable to us, and we are grateful  
to you for the brief and for your attendance here.  
Thank you.





THE CHAIRMAN: Thank you very much.

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sincere discussion from the long experience of Dr.  
cases will be very valuable to us, and we are grateful  
to you for the brief and for your attention here.  
I am, you,



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TORONTO, ONTARIO

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THE SECRETARY: Mr. Chairman, the next submission will be that of the Canadian Association of Social Workers and it will be known as Exhibit 330, and Miss Denault will come forward to introduce her group.

--- EXHIBIT NO. 330: Submission of the Canadian Association of Social Workers.



submission will be that of the Canadian Association of  
social workers and it will be known as Exhibit 300,  
and Miss Bennett will come forward to introduce her  
group.

--- EXHIBIT 300: Submission of the Canadian  
Association of social workers.





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SUBMISSION OF  
CANADIAN ASSOCIATION OF SOCIAL WORKERS

APPEARANCES: Miss H. Denault  
Miss Joy Maines  
Miss B. Michaud  
Miss K. Taggart  
Mr. Trevor Pierce

THE CHAIRMAN: Yes, Miss Denault.

MISS DENAULT: Monsieur le président,  
les commissaires, Mademoiselle Girard, permettez-moi  
d'abord de vous dire que nous sommes heureux d'être  
ici et de vous adresser quelques mots en français,  
parce que je suis de Québec.

May I first introduce my colleagues  
who have come to join me in presenting our brief to the  
Royal Commission and who will be glad to answer any  
questions you may want to ask about it. First, at my  
right is Miss Joy Maines, Executive Director of the  
Canadian Association of Social Workers. Miss Maines  
knows more than anyone about the organization and the  
development of our professional association.

Next is Miss Beth Michaud from Montreal,  
Director of the Department of Social Service of the  
Notre Dame Hospital. Next is Miss K. Taggart from  
Toronto presently Executive Director of the Visiting  
Homemakers of Toronto and who has also had experience  
in Saskatchewan with the Department of Social Welfare.  
The next is Mr. Trevor Pierce of Toronto presently with  
the Ontario Welfare Council who has had experience  
with the Ontario Anti-Tuberculosis Organization.



PRESENTATION OF  
CANADIAN ASSOCIATION OF SOCIAL WORKERS

Miss H. Denault  
Miss Joy Waines  
Miss S. McDonald  
Mr. Trevor Haines

ANNOUNCEMENT:

THE CHAIRMAN: Yes, Miss Denault.

MISS DENAULT: Monsieur le Président, les commissaires, l'honorable M. Girard, permettez-moi d'abord de vous dire que nous sommes heureux d'être ici et de vous adresser quelques mots en français, par ce que je suis de Québec.

Now I first introduce my colleagues who have come to join me in presenting our brief to the Royal Commission and who will be glad to answer any questions you may want to ask about it. First, at my right is Miss Joy Waines, Executive Director of the Canadian Association of Social Workers. Miss Waines knows more than anyone about the organization and the development of our professional association.

Next is Miss Beth Mitchell from Montreal, Director of the Department of Social Service of the Notre Dame Hospital. Next is Miss K. Stewart from Toronto presently Executive Director of the Visiting Homekeepers of Toronto and who has also had experience in co-operation with the Department of Social Welfare. The next is Mr. Trevor Haines of Toronto presently with the Ontario Anti-Slavery Society who has had experience with the Ontario Anti-Slavery Society.



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4 Before speaking of the brief itself  
5 I wish to say a few words about the Canadian Association  
6 of Social Workers of which I have the honour of being  
7 presently the president. This is a national professional  
8 association for the social workers of Canada. The  
9 Association has a membership of nearly 2,700 and the  
10 members are men and women speaking French or English  
11 and practising in all provinces from Victoria to Sydney  
12 and St. John's Newfoundland. If I may say, the pro-  
13 fession in the field of social work is what is called  
14 and related to social welfare, it is a field of physical  
15 and mental welfare for every person. I think we could  
16 also call it the field of social health.

17 In his practice a social worker  
18 aims at the recovery or maintaining of social health of  
19 the persons in the families and groups and institutions.  
20 His field is the field of social functioning, in the  
21 areas of personal or family economics and conducts  
22 their work in social relationships who may be families  
23 or children or delinquents or other kinds of handicapped  
24 persons. Very often the clients are the physically or  
25 mentally ill. Social work is practiced in a great  
26 variety of social institutions, agencies and departments  
27 among which we find a great number of hospitals, clinics  
28 and different other health organizations at the local,  
29 provincial and national levels. Our brief has under-  
30 lined these varied professional activities and concerns  
of the social workers. This is why it is divided into  
three definite parts. Our recommendations have grown  
out of the more detailed information contained in the





THE CANADIAN ASSOCIATION OF SOCIAL WORKERS

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Manitoba

Before speaking of the field itself

I wish to say a few words about the Canadian Association of Social Workers of which I have the honour of being presently the president. This is a national professional association for the social workers of Canada. The Association has a membership of nearly 2,700 and the members are men and women speaking French or English and practising in all provinces from Victoria to Prince Edward Island. If I say any, the profession in the field of social work is what I consider related to social welfare, it is a field of human and mental welfare for every person. I think we could also call it the field of social health.

In the practice of social work we

aim at the recovery, maintenance of social health of the persons in the families and groups and individuals. This field is the field of social functioning, in the sense of personal or family, economic and social functioning work in social relationships who may be involved in children or adolescents or other kinds of handicapped persons. Very often the clients are the physically or mentally ill. Social work is now in a great variety of social institutions, agencies and departments among which we find a great number of hospitals, clinics and different other health organizations at the local, provincial and national level. Our brief has underlined these varied professional activities and services of the social workers. This is what is different from those definite ones. Our recommendations have shown that of the more detailed information contained in the



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4 brief and with your permission I will now read these  
5 recommendations relating to each part of the brief.

6 The Canadian Association of Social  
7 Workers, in the accompanying submission, makes recommenda-  
8 tions to the Royal Commission on Health Services under  
9 the following headings:

10 I. The Contribution of the Social Worker to Medical Care

11 "That the Royal Commission recognize that:

- 12 i) a Social Service Department is an essential  
13 part of a hospital or medical treatment  
14 institution, whenever that institution is  
15 sufficiently large to support the service;  
16 ii) to give effective service, such Departments  
17 should be staffed by professionally qualified  
18 social workers;  
19 iii) the appointment of social workers to county  
20 health units should be encouraged to supply  
21 professional service in small hospitals, to  
22 assist with the social problems of ill people  
23 in their own homes, and to facilitate the  
24 movement of persons to and from medical centres  
25 when this is necessary;  
26 iv) many patients receiving medical care from  
27 private practitioners do not have available  
28 to them, the services of professional  
29 social workers, and as social problems related  
30 to illness are not confined to persons  
requiring hospital or institutional treatment,  
the medical practitioners should be encouraged  
to make use of social workers attached to



brief and with your department I will now send the  
 recommendations relating to each part of the bill.  
 The Canadian Association of Social

workers, in the accompanying submission, makes recommenda-  
 tions to the Royal Commission on Health Services under  
 the following headings:

1. The Contribution of the Social Worker to Medical Care  
 "That the Royal Commission recognize that:

- (i) A Social Service Department is an essential part of a hospital or medical treatment institution, wherever that institution is sufficiently large to support the service; to give effective service, such Department should be staffed by professionally qualified social workers;
- (ii) the appointment of social workers to community health units should be encouraged to supply professional service in small hospitals, to assist with the social problems of ill people in their own homes, and to facilitate the movement of persons to and from medical institutions when this is necessary;
- (iv) many patients receiving medical care in private practitioners do not have facilities to them, the services of social workers, and as such, professional help to them are not considered to be essential; the medical practitioners should be encouraged to have use of social workers attached to





Denault

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public and private community agencies when  
their patients need the help of a social  
worker."

II. The Interdependence of Health and Welfare Services:

"That the Royal Commission recognize that:

- i) a national health program will be limited  
in its effectiveness unless the supporting  
welfare services are also strengthened. This  
means the development of new services, in some  
instances, such as the provision for loss of  
income due to the illness of the breadwinner;  
in other instances, it means the expansion of  
services now available in some communities  
to other areas, or their expansion within a  
community to make adequate provision: for  
example, convalescent hospitals, homemaker  
services, or the provision of prosthetic  
appliances;
- ii) the close co-ordination of health and welfare  
services is necessary if the provision of  
medical care is to be effective in developing  
a physically and mentally healthy population;
- iii) the pattern of services must be dictated by  
varied needs of sick people, and not be  
compartmentalized for the sake of apparent  
administrative simplicity."

III. A National Program for Personal Health Care.

"We therefore recommend to the Commission that:

- i) the government should establish a program to  
make available to all persons living in Canada,



public and private community assistance with  
 their patients need the help of a central

II. The Interdependence of Health and Welfare Services

What the Royal Commission recognizes that:

i) a national health program will be limited  
 in its effectiveness unless the supporting  
 welfare services are also strengthened. This  
 means the development of new services, in some  
 instances, such as the provision for loss of  
 income due to the illness of the breadwinner;  
 in other instances, it means the expansion of  
 services now available in some communities  
 to other areas, or their expansion within a  
 community to make adequate provision for  
 example, convalescent hospitals, for mental  
 services, or the provision of psychiatric  
 applications

the close co-ordination of health and welfare  
 services is necessary if the provision of  
 medical care is to be effective in developing  
 a physically and mentally healthy population;

the pattern of care must be directed to  
 various needs of each person, and not to  
 conditions realized for the sake of operational  
 administrative convenience.

III. Recommendations for National Health Care

"The Government should... to the... that  
 the Government should... to...  
 make available to a... in Canada



Denault

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- i) comprehensive health services;
- ii) the program be financed by taxes;
- iii) the services be available to all persons domiciled in Canada without distinction;
- iv) the plan be administered in such a way as to provide adequate citizen participation in the policy-making body;
- v) the plan not to include deterrent payments or co-insurance."

IV. The Shortage of Social Workers.

"We therefore recommend:

- i) That the Commission adds its support to the representations already made to the federal government; that welfare training grants be made available to assist students to undertake professional training in social work; and to extend the facilities of the Schools to enable them to increase their enrolment."

Since the submission of the brief we have had assurance that welfare training grants shall be available in the future and that a National Council of Welfare will be established. I think, Mr. Chairman, that this ends the presentation on the brief and our recommendations.

THE CHAIRMAN: Thank you very much, Miss Denault.

COMMISSIONER GIRARD: I would like to bring this question to you: On page 14 you say that the accepted qualification for admission into the profession is a master of social work awarded after the satisfactory





comprehensive health services;  
the program be financed by taxes;  
the services be available to all persons  
enrolled in the plan without distinction;  
the plan be administered in such a way as to  
provide adequate financial participation in the  
policy-making body.  
the plan not to include dependent payments

ON CO-INSURANCE  
IV. The Structure of Social Insurance

"We therefore recommend:  
1) That the Commission have its report to the  
representations already made to the Federal  
Government, that welfare training exist, and  
make available to assist students to conduct  
and seasonal training in social work, and to  
extend the facilities of the school to enable  
them to increase their enrollment."

Since the submission of the report we  
have had assurance that welfare training courses shall  
be available in the future and that a National Council  
of Welfare will be established. I think, Mr. Chairman,  
that this ends the presentation on the labor and can

MR. CHAIRMAN: "Thank you very much."

Thank you.  
... I would like to  
bring this question to you: On page 14 you say that the  
accepted participation for education that the profession  
is a matter of social work, whether the health service



Denault

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4 completion of two years of professional education. On  
5 Appendix 1, the last paragraph you say there is require-  
6 ments for the admission into the association, the  
7 minimum required is one year of professional social work  
8 and you say in 1964 it will go on to two years. How do  
9 you explain these two statements? Do you have different  
10 qualifications for admission to your Association different  
11 from admission to the profession?

11 MISS DENAULT: I think I will leave  
12 the answer to Miss Maines who has had long experience  
13 with the Association.

14 MISS MAINES: In reply to this question,  
15 your point is perfectly well taken. The Association at  
16 the present time does admit to membership persons who  
17 have completed one year of professional training and,  
18 at the same time, our goal is to achieve a two years  
19 professional training. We will say to students that they  
20 should complete the two years of training but the demand  
21 has been so great from the field for filling positions  
22 that we are badly in need of social workers and employers  
23 have been glad to take persons with one year of training.  
24 We hope this situation will be overcome in the reasonably  
25 near future so that all people will be required to have  
26 completed the two years professional training.

25 COMMISSIONER GIRARD: What does the  
26 student get after one year professional training, does  
27 she get any type of recognition or is the second year  
28 a field training period?

29 MISS MAINES: No, at the end of the  
30 first year of professional training in some provinces in



completion of two years of professional education, in  
Appendix I, the last paragraph you say there is no direct  
rents for the admission into the association, the  
minimum required is one year of professional social work  
and you say in 1939 it is one or two years. How do  
you explain these two statements? Do you have different  
qualifications for admission to your association at these  
times?  
The answer to the question is that the minimum  
with the Association.  
The answer is that in 1939 it was one year of  
training in a hospital with a year of a hospital with a  
the present time is one year of professional education who  
have completed one year of professional education, and  
at the same time, our goal is to achieve a two years  
professional training. We will say to students that they  
should complete the two years of training for the hospital  
has been so great from the field for future positions  
that we are having a need of social workers and a feeling  
have been given to the persons with one year of training,  
we hope this situation will be overcome in the near future  
near future so that all people will be required to have  
completed two years professional training.  
The answer is that the minimum requirement for the  
student get after one year professional training, then  
we get any type of recognition as to the second year  
of field training period.  
The answer is that at the end of the  
first year of professional education, the student is required to





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4 Canada they receive a Bachelor of Social Work degree;  
5 in certain other provinces they are given a certified  
6 statement that they have completed one year and are  
7 eligible to return for the second year. This depends  
8 on the universities.

9 COMMISSIONER GIRARD: So that when you  
10 bring up the recommendation 64 that everyone must have  
11 two years will this also increase your shortage of  
12 social workers?

13 MISS MAINES: We do not feel so.

14 COMMISSIONER GIRARD: You do now have  
15 a shortage as other professions in the health field  
16 apparently has?

17 MISS MAINES: Yes, we are suffering  
18 from it the same as the others and we feel very definitely  
19 the two years should be recognized as a professional  
20 qualification. We hope to encourage everyone to complete  
21 the two years.

22 COMMISSIONER GIRARD: Is there any  
23 place in the profession of social work for an auxiliary  
24 person, an assistant to social workers or something of  
25 that type we are getting now in almost all other health  
26 professions, a second type of person that can help  
27 relieve the shortages?

28 MISS MAINES: I think we would say  
29 that these people do exist at the present time in the  
30 field of social work. One of the difficulties today, and  
we are I think cognizant of it, is that a full analysis  
in relation to job classification needs to be made in the  
welfare field. As yet the types of work that can be done





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3 by auxiliary personnel have not been definitely defined  
4 as they have, say, in the field of nursing or medical  
5 care. For instance, it might be simple enough to teach  
6 someone to take a person's temperature physically but it  
7 is not quite so easy to discover what is the sort of  
8 social problem in any given situation.

9 COMMISSIONER GIRARD: You have another  
10 recommendation saying that you would like to see a  
11 social worker in every county health unit or every health  
12 unit -- I do not know whether you stated county health  
13 unit or not. How many social workers are presently  
14 employed in health units in the Province of Ontario? How  
15 prevalent is this person?





by auxiliary personnel have not been definitely de-  
lined as they have, say, in the field of nursing or medical  
work. For instance, it might be quite enough to refer  
someone to take a person's temperature physically but it  
is not quite so easy to discover what is the sort of  
social problem in any given situation.

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employed in health units in the Province of Ontario? Is  
present is the person.



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MR/ss

MISS MAINES: It is not prevalent. At the present moment there are some Metropolitan Health Units, for example, in the City of Vancouver. I know that social workers are attached to the health unit there, but insofar as county health units in the Province of Ontario, for example, I would think there are none that I know of.

COMMISSIONER GIRARD: You recommend there should be?

MISS MAINES: I think this was a means of where it would be impossible, perhaps, for every small hospital to have social workers attached to them. It might be completely uneconomic. If there were county health units in an area with social workers attached to that unit, they could perhaps serve the local hospitals in the area.

COMMISSIONER GIRARD: She would be a consultant and not do case work herself? She would act in the capacity of a consultant to the agencies? To the small hospital or to the agencies? Is that the way you see it?

MISS MAINES: I would think that is the way it would work out. I believe there has been some Western experience in this, has there, Miss Taggart, in county units in Saskatchewan?

MISS TAGGART: I am not aware of any.

COMMISSIONER GIRARD: But you would like to see this established?

MISS MAINES: I think that is an area that might be developed. We do not see it in the



At the present moment there are some 150,000...

Health units, for example, in the City of New York...

know that social workers are attached to the health...

units, but perhaps on a smaller scale in the private...

of Chicago, for example, I would think there are some...

that I know of.

There is a...

UNITED STATES. I think this was a...

of which it would be impossible, perhaps, to know a...

hospital to have such a wide area attached to it...

might be completely impracticable. It seems to me...

health units in an area with social workers...

that unit, they could perhaps serve the needs...

in the area.

COMMUNITY HEALTH: It is...

convenient and not so close with health...

in the capacity of a consultant to the hospital...

with hospital or to the community. It is...

and...

It is...

the health unit would not. I believe that...

in the area, as the health unit...

health unit in the area...

It is...

It is...

to the health unit...

It is...

It is...





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immediate future. This is an area that could be developed.

COMMISSIONER GIRARD: Thank you very much.

THE CHAIRMAN: You are social workers and we accept you are the people who are perhaps closest to those who may be in need of health services and may find it difficult to get them. Is that a fair assumption of your position in the health field?

MISS DENAULT: I am sorry, but I did not get the question.

---(Commissioner Girard interprets question in French)

THE CHAIRMAN: Miss Maines or Miss Taggart or Miss Michaud. The idea is we are concerned with what is being said.

MISS DENAULT: I understand what you are asking.

THE CHAIRMAN: That people are not able to get a doctor, or have the services of a doctor when they need a doctor and so I want to put this question to you : From your experience, and you represent an organization that has knowledge in this field. I mean that is why your answer could be of value to us. From your experience in working in the field, or the case workers under you, is it a fact that people are going without physicians' services merely for lack of money?

Has anybody gone without the services of a doctor merely because that person had no money?

MISS TAGGART: I think the section of



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immediate future. This is an area that could be developed.  
COMMISSIONER: Thank you very

THE CHAIRMAN: You are social workers  
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MISS KATZ: I am sorry, but I did  
not get the question.

---(Commissioner's question in French)

THE CHAIRMAN: Miss KATZ, on this  
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with what is being said.  
MISS KATZ: I understand what you  
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experience in working in the field, or the case workers  
now you, is it a fact that people are going without  
services, services which are in many  
anybody going without the services  
of a doctor have a hard time getting a doctor and in many  
cases, I think, the reason of



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the brief that deals with the interdependence of health and welfare services, we tried to outline some of the areas where we think this is true.

THE CHAIRMAN: I am talking now not of generalities, but of individual situations. Isolated or pronounced, as you may have found.

MISS TAGGART: I think the biggest group that concerns us are the so-called medically indigent group. The low income group.

THE CHAIRMAN: They are the people I am talking about too.

MISS TAGGART: It is our experience with them that many of them, because of lack of money, fail to get health services. They may get emergency medical care with acute illness, but if they do not have the money to pay the doctor, first of all, they would be reluctant to seek his assistance.

THE CHAIRMAN: That is one phase of it. I am talking about where they do ask for medical service. Have they been refused medical service merely because they have not the money?

MISS MICHAUD: I am afraid it is impossible to answer yes or no, because in practice it is not that simple. A person might not be refused, let us say, attendance at the clinic free but it could be so complicated, so difficult for the mother to wait three hours and to discuss with the accounting department, and so on, that certain persons prefer not to get the service.

In our experience we find that some patients have difficulty in accepting the procedures that







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are too complicated, if they are to get free care, and often some patients will say, "Well, I had to go without medication".

If you enquire, of course, you will not find that the patient went to the last recourse. Tried everything possible, but on the other hand with this kind of situation maybe you do not blame the person who is already sick and loaded with responsibilities to give up if she is not acutely ill.

THE CHAIRMAN: Perhaps I will make the question a little more specific. Do these things come to you as social workers, or to your agencies that so and so has called a doctor and the doctor has refused to give his service until he was paid in advance? Said, "I won't go unless I get paid"? Anything like that?

MISS DENAULT: In my experience I think I could say that I have never experienced an attitude like that from a doctor.

THE CHAIRMAN: From the medical profession, once they are asked.

MISS DENAULT: But the difficulty, if we speak of what we call the medically indigent, who are not the real economically indigent, because these indigents usually receive all kinds of public service in hospitals and even from doctors, but the persons of middle means ---

THE CHAIRMAN: Now, you are going into another category.

MISS DENAULT: This is a category that we see very often in the social work who have lots of







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social difficulties, of all kinds, and with their medical or health problems they are really worried. They don't go to see a doctor when they would need to, because they are shy about it so they don't want to spend their money on that, or then they go into debts and this is the problem in ditching in the budget, the middle ----

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THE CHAIRMAN: Just above the indigent.

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MISS DENAULT: Above the indigent.

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THE CHAIRMAN: Above the indigent and before being completely self-supporting.

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MISS DENAULT: The persons who did not use to be qualified for public assistance.

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COMMISSIONER McCUTCHEON: You said they did not want to spend their money for that. That indicated that they had money, but preferred to spend it on something else.

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MISS DENAULT: Well, they need, you see their incomes are very narrow and every cent is counted and if they do not want to go into the ditch with budget, they wait and wait, until they are too sick.

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MISS TAGGART: Perhaps I could add a point to that. I think we find a lot of parents, mothers and fathers that did not want to seek medical care because it is going to deprive their children. It is going to come out of the food budget, or come out of the youngsters' clothing budget, or something like this. A mother who has heavy medical expenses may feel very guilty about this if her family are suffering on account of it, and we do run into this.

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COMMISSIONER VAN WART: In many of the





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immunization clinics where the service is free do you have difficulty in getting these people to come to that?

MISS TAGGART: No, I wouldn't think particularly.

COMMISSIONER VAN WART: You have to go to their homes and prod them to get them out, don't you?

MISS TAGGART: I don't think the social workers would be involved in that so much.

THE CHAIRMAN: You see, this is fundamental. This question that we put to you now, we think is fundamental, what your recommendation number 3 is aimed at, because you advocate a comprehensive health service plan. Now then, how comprehensive? What do you mean by comprehensive in this context of 3 (1)?

MR. PIERCE: I think that we are concerned with a program that has few exceptions and has few limitations as possible in terms of the kinds of service that are available, and also the exceptions in relation to people as groups or as individuals who cannot now receive the kind of service that we are advocating.

For instance, many people now through existing programs are able to provide for themselves through prepaid schemes, and so on, but generally speaking these are in preferred categories in the sense that they are generally the people who are employed and able to take care of the day to day expenses.

We are concerned with these other people who we know from our own experience have difficulties in this area.

THE CHAIRMAN: Now, would you disturb the





...organization which the services is free do you  
have difficulty in getting these people to come to it?  
MISS WATSON: No, I wouldn't think

it would.

COMMISSIONER VAN WAT: You have to go  
to a lot of places and press them to get them out, don't you?  
MISS TAYLOR: I don't think so.

...social workers would be involved in that work.

THE CHAIRMAN: You say, this is

...that is a question that we are not going to

...this is the first question, what was the representation number 3  
...to which it, I think, is a question of the representation number 3  
...which is then, now, I think, it is a question of the representation number 3

...mean by representation in this context of 3 (11)

MR. TAYLOR: I think that we are

...concern with a program that has few exceptions and has

...law limitations as well as in terms of the law of

...services that are available, and also the exception is

...relation to people as well as individuals and women

...new relative the kind of service that we are discussing.

...in a statement, many people are in a position

...exist in a program and able to provide for themselves

...through people in the past, and so on, but a relative

...and these are in preferred categories in the sense

...that they are going to be the people who are employed and

...able to take care of the day to day expenses.

...as the concern with these other

...people who we know from our own experience have a difficult

...this area.

THE CHAIRMAN: Now, you are going to



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situation of those who are already covered or would you leave them alone and be concerned with those who are not able to get coverage?

MR. PIERCE: Our concern is that if in order to get the kind of comprehensive, universal service that we would like to see, if this means a readjustment, a re-planning over a period of time, as we have seen to some degree in the provision of hospital service, then we would say we would like to see this developed, if this is the only way that we can provide this comprehensive coverage.

We do recognize, and we say in the brief many are covered in this way, but they are people paying for themselves, because they happen to be in that position.

THE CHAIRMAN: So the question comes, I think must come, is what you are recommending here something that will replace that, or is it something that you want additional to that? Additional so that it would cover those who cannot obtain coverage for themselves?

MR. PIERCE: Concerned about something additional.

THE CHAIRMAN: No, but I mean would you direct your reply to the question. Are you looking for something to replace what is now available to some large section of the population. We have been given various figures from 50 to 65%. Larger in some provinces than others.

Do you want to replace that with one system for all, or do you want to leave that system that



...of those who are a really covered on really you  
 leave the alone and be associated with those who are  
 not able to get covered?

MR. TILLEY: Yes, sir. That is what I  
 in order to get the kind of coverage, and to be  
 service that we would like to see, if this means a  
 result, a re-arranging over a period of time, as  
 we have seen in some degree in the situation of medical  
 service, then we would like to see this to be  
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 developed, if this is the only way that we can get  
 this comprehensive coverage.

I think that cover is what we are recommending here.  
 something that will replace that, or is it a thing  
 that you want to add to that? Additional to that it  
 would cover those who are not obtain coverage for a service.

MR. TILLEY: Continued along a similar  
 additional.

MR. TILLEY: Yes, sir. That is what I  
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 developed, if this is the only way that we can get  
 this comprehensive coverage.





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is there and have added to it, in some way, a program which would cover those who are not able to obtain coverage for themselves?

MR. PIERCE: I think it would be fair to say that we would prefer to see a replacement, nevertheless building on the experience ----

THE CHAIRMAN: Why?

MR. PIERCE: Because we feel that this would avoid the placing of citizens in different categories, related, for instance, to their ability to purchase service.

We feel that this is a right that people have and if we can devise a scheme that will make comprehensive service available to all citizens, and if this requires a replacement of the present kinds of program, then I think we are saying we would like to see a replacement which would, in effect, be a development from the experience that we have had up to date in the sense that we have had this experience in relation to hospital service.



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is there any other way to do it, a program

which we are trying to do in the future

concerning the program

Mr. Pitt: I think it would be fair

to say that we would never see a replacement, never-

theless building on the existing one ---

Mr. Pitt: Because we feel that this

would avoid the mixing of elements in different categories

related, for instance, to their ability to respond

services.

We feel that this is a point that

people have and we can devise a scheme that will work

comprehensive service available to all citizens, and in

this requires a replacement of the present kind of pro-

gram, then I think we are saying we would like to see a

replacement with a word, in fact, as a replacement from

the experience that we have had up to date in the sense

that we have had this experience in relation to municipal

services.



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THE CHAIRMAN: So you have given some thought to what ought to be?

MR. PIERCE: Well, I am afraid that we haven't given detailed thought to the kind of program.

THE CHAIRMAN: But you have given some thought to it, so do you see it as a program operated by the Federal Government, or in what manner?

MR. PIERCE: Well, we recognize, of course, that again related to experience up to date, and the history of services in Canada, that we are not suggesting complete abolition of provincial responsibilities, but we would like to see a comprehensive national plan which makes it possible for the plans that may be developed in the individual provinces to be of a kind where, if a person has to move from one place in Canada to another, then he can still receive the same kind of health services.

THE CHAIRMAN: And then you say it should be financed by taxes. That means somebody has to collect the taxes?

MR. PIERCE: Yes.

THE CHAIRMAN: Who would be the collector?

MR. PIERCE: We feel in relation to the financing of the services through taxes, that perhaps this is the most satisfactory method in the long run of relating the provision of service in relation to the ability of the individual to pay. In other words, this avoids a means test.







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We have, through income tax, an income test, which is already well-established and in this way every individual has the opportunity to contribute towards the payment of the services related to the income and if a person does not receive any income then presumably within this kind of system, which is financed through taxes, no individual would suffer because of his inability to pay for those services.

COMMISSIONER McCUTCHEON: You mentioned a right a minute ago. What about the right to good housing, the right to nutritious food, the right to decent clothing? Do you take those into the scheme?

MR. PIERCE: Well, I think our feeling here ---

COMMISSIONER McCUTCHEON: We had the proposition put to us in one province that you should not have a means test, that if I needed \$100 I should be able to walk into the welfare office and get it. It would be humiliating enough for me to ask for the \$100 and I should not be asked any more questions.

If you are recommending a scheme such as you now outline in the health field, what would be the other fields of welfare? Do you want the same thing?

MR. PIERCE: I think we would have some distinction here. We certainly recognize that health is vitally important, not only to the well-being of the citizen, but also to society as a whole.

COMMISSIONER McCUTCHEON: But so is food.



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we have, especially in the case of income  
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 every individual has the opportunity to contribute  
 towards the payment of the services related to the  
 income and if a person does not receive any income  
 then practically within this kind of system, which is  
 financed through taxes, an individual would suffer  
 because of his inability to pay for these services.

What about the right to food  
 housing, the right to medical care, the right to  
 decent clothing? Do you take these into the account?

---  
 I think we had the  
 proper food but to us in one province that you should  
 not have a means test, that if I needed \$100 I should  
 be able to walk into the welfare office and get it.  
 It would be good enough for me to eat for the  
 day and I should not be asked any more questions.  
 If you are recommending a means test,

as you now operate in the health field, what would be  
 the effect of welfare? Do you want the same?

---  
 I think we would have  
 some distinction made. No certainly we would have  
 which is very important, not only to the welfare  
 of the citizen, but also to society as a whole.

---  
 I think we would have





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MR. PIERCE: We certainly would agree, I think, but in this particular instance our concern is that a comprehensive scheme of the kind that we have in mind is important to the well-being of society and that it is a responsibility of society, as well as a right of the individual within this kind of society to receive this kind of service without question as to his ability to pay for it.

THE CHAIRMAN: We are merely trying to discuss the thing as a matter of principle. I mean, this thing, whichever way you may put it, of being healthy, is important. I mean, being in good health is important and I suppose it is of equal importance that you should have some food to eat.

Now, those who are unable to provide food and shelter for themselves are now being taken care of by the various social agencies and by government, under social welfare. That is the fact, isn't it? And to qualify for that service, for that assistance, they naturally undergo some form of qualification test. Do they not?

Now, you say that it is not a desirable thing that there should be a similar qualification test for medical services. Can you tell me what difference, if any, there is between qualifying for food and shelter on the one hand, or for health services on the other, in quality of the test?

MR. PIERCE: I think that in as far as the individual is concerned, within certain limitations perhaps the individual can do much more about his



...the country will agree  
I think, but in this case it is our concern  
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other, in quality of the tests

MR. LITTON: I think that is as far  
as the individual is concerned, with certain limita-  
tions perhaps the individual has to make a more and more



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poverty than he can about his sickness.

THE CHAIRMAN: Oh, no, no. We are talking about the ones who are not able to, and for whom the State is making provision now, and there are several hundred thousands. I mean to say, it is about 8% of 18 million, that would be a million and some hundred thousand, anyway, for whom provision is made. They are buying food. The State is providing food and shelter and clothing on a means test, as you would appreciate.

Now, when you come to discuss medical or health services, you say the means test is something abhorrent. What is the essential difference? I mean, we are looking for somebody to tell us what that difference is, in fact.

MISS DENAULT: We see a little difference in that, because the means test to the indigent person for general economic reasons, that will be accepted by persons who cannot work, or cannot get work or cannot have to receive something to be able to live and eat, but that in the medical field, in the medical care, the need is extended to a part of society that might not be covered by these 8% of 18 million.

THE CHAIRMAN: I am talking about the same people that you are.

MISS DENAULT: But I am thinking of extending the services.

THE CHAIRMAN: No, let's just say with the same people and let us see the difference.

MISS DENAULT: I will let Mr. Pierce





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poverty than he can about the sickness.

THE CHAIRMAN: Oh, no, no. We are

talking about the ones who are not able to, and for whom the State is making provision now, and there are several hundred thousands. I mean to say, it is about 84 of 18 million, that would be a million and some hundred thousands, anyway, for whom provision is made. They are having food. The State is providing food and shelter and clothing on a means test, as you would

Now, when you come to discuss medical or health services, you say the means test is something arbitrary. What is the essential difference? I mean, we are looking for somebody to tell us what that difference is, in fact.

MISS BROWN: We see a little difference in that, because the means test to the individual person for mental economic reasons, that will be accepted by persons who cannot work, or cannot get work or cannot have to receive something to be able to live and eat, but that in the medical field, in the medical care, the need is extended to a part of society that might not be covered by these 84 of 18 million.

THE CHAIRMAN: I am talking about the

same people that you are.

MISS BROWN: But I am thinking of

extending the services.

THE CHAIRMAN: No, let's just say with

the same people and let us see the difference.

MISS BROWN: I will try to, please.



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answer that.

THE CHAIRMAN: "I don't want to be difficult or anything about it, but this thing keeps recurring all the time. It is humiliating, it is degrading, it is demoralizing, it is this, that, and the other thing, to have to go through a means test for health services, but it seems to be quite accepted and has none of those characteristics when it is applied to food and shelter and clothing and the others.

MR. PIERCE: "I don't think this is our position, that we are saying that the means test for the general welfare assistance is acceptable, whereas it is not acceptable in relation to health services. I don't think this is our position at all.

THE CHAIRMAN: Well, all right, you would say you would have no means tests on either score, is that it?

MR. PIERCE: No, I don't think we would say that either.

THE CHAIRMAN: Well, you ought to be practical or you are going to get yourself into difficulty, aren't you?

MISS MICHAUD: I wonder if the reason not to have a means test for health services is really that we feel that psychologically it is so hard on the people?

THE CHAIRMAN: That is a very fair way of putting it.

MISS MICHAUD: No population is apt to get sick one day or another. That is a general risk for



Answer that.

THE CHAIRMAN: I don't want to be

difficult or anything about it, but this thing keeps

recurring all the time. It is humiliating, it is

degrading, it is demoralizing, it is this, that, and

the other thing, to have to be dependent on others for

for health services, but it seems to be quite accepted

and has none of those characteristics when it is

applied to food and shelter and clothing and the others.

MR. PIERCE: I don't think this is

our position, that we are saying that the means test

for the general welfare assistance is acceptable, whereas

it is not acceptable in relation to health services.

I don't think this is our position at all.

THE CHAIRMAN: Well, all right, you

would say you would have means tests on other things,

is that it?

MR. PIERCE: No, I don't think we

would say that either.

THE CHAIRMAN: Well, you cannot be

practical on your side going to eat yourself into this

THE CHAIRMAN: I wonder if the reason

of it is that we have a feeling that health services are really

what we feel that psychologically it is so hard on the

THE CHAIRMAN: That is a very fair way

of putting it.

THE CHAIRMAN: Mr. Pierce, I am

not sure one way or the other. That is a very fair way





Michaud

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the population. The risk to get indigent is not so general and I suppose some technicians could tell us better than we know, but it seems that it is more practical, it is more economic, when you have a general risk, not to go into all these inquiries.

THE CHAIRMAN: That you take care of everybody who can take care of themselves to cover those who cannot take care of themselves?

MISS MICHAUD: Well, they pay back in the income tax. In other words, this system has been applied already for old-age pension and hospital insurance and it seems practical, when the risk is general for the whole population.

COMMISSIONER McCUTCHEON: The system has not been applied in the way you describe it in all provinces for hospital insurance.

THE CHAIRMAN: It has not been universally applied in Ontario.

MISS MICHAUD: No.

COMMISSIONER McCUTCHEON: What do you include in health services?

MR. PIERCE: Well, we would, as we have indicated in the brief, we are thinking certainly beyond purely medical treatment when a person is sick and in need of medical ---

THE CHAIRMAN: So you have physician services?

MR. PIERCE: Physician and ---

THE CHAIRMAN: Are you going to have nursing services?



the population. The risk to get involved is not so general and I suppose some decisions could tell us better than we know, but it seems that it is more practical, it is more economic, when you have a general risk, not to go into all these inquiries.

THE CHAIRMAN: When you take care of

everybody who can take care of themselves to cover

those who cannot take care of themselves.

MRS. MICHAEL: Well, they pay back in

the income tax. In other words, this system has been

applied already for old-age pension and hospital

insurance and it seems practical, when the risk is

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COMMISSIONER McLEOD: The system

has not been applied in the way you describe it in all

provinces for hospital insurance.

THE CHAIRMAN: It has not been univer-

sally applied in Ontario.

MRS. MICHAEL: No.

COMMISSIONER McLEOD: What do you

include in health services?

MRS. FINKEL: Well, we would, as we

have indicated in the brief, we are thinking certainly

beyond purely medical treatment when a person is sick

and in need of medical care.

THE CHAIRMAN: So you have my friend

the Minister of Health and

the Minister of Social Services to have

nothing to do with it.



Pierce

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MR. PIERCE: Nursing services.

THE CHAIRMAN: Dental services?

MR. PIERCE: Dental services.

THE CHAIRMAN: Prescription of drugs?

MR. PIERCE: The prescription of drugs and prosthetics and the kind of social service which we feel is basic to the provision of good health services, since we feel that health and welfare services are really indivisible. We do not feel that these can be separate, that we have to plan for these as one entity, because we are concerned with the health and the well-being of the individual in the broadest sense.

COMMISSIONER McCUTCHEON: Do you include homemaker services?

We feel that these may be in a different category as far as importance is concerned, but we certainly feel that these are an essential part of the services. Whether they be labelled health or welfare services is a moot point, but our point is that they not be separated when we are thinking of a family situation when sickness hits; that all the services required to bring this family back to as normal a position as possible, that these services are provided on a comprehensive and universal basis.

THE CHAIRMAN: You would give that then -- I don't want the word give to have any special connotation -- you would make provision for that for everybody in Canada?

MR. PIERCE: Yes.

THE CHAIRMAN: Without payment of





THE CHAIRMAN: I will say that.

MR. BIRNBAUM: The prescription of drugs  
and the prescription of drugs?

and the prescription of drugs and the kind of service which  
is given to the population of good health  
services, since we feel that health and welfare services  
are really indivisible. We do not feel that there can  
be separate, that we have to put in these as  
entity, because we are concerned with the health and  
the well-being of the individual in the broadest sense.

THE CHAIRMAN: Now, do you

include these other services?

We feel that they may be in a  
different category as far as importance is concerned,  
but we certainly feel that these are an essential  
part of the service. Whether they be labelled health  
or welfare services is a moot point, but my point is  
that they not be separated when we are talking of a  
family or a community health plan; that the  
services included to bring this family plan to us are  
a part of the service, that these services are indivisible  
and that we must have and make that clear.

THE CHAIRMAN: You would give a

name -- I don't want the name give or have an approved  
organization -- you would like to have for that?

Everywhere in the country.

THE CHAIRMAN: Yes.

THE CHAIRMAN: I don't see that



Pierce

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premium, or without contribution from the individual, except as you might be able to reach him through income tax?

MR. PIERCE: That is right.

COMMISSIONER STRACHAN: On a limited budget, would you not be afraid, under such a suggested scheme, that the social services might be the first to suffer?

MR. PIERCE: This is certainly a possibility, of course. We have looked at this, because we see the failures to individuals in the present system. In other words, the gaps that affect the individuals who are caught between the limitations of existing schemes, and we see this possible approach of the provision of services through taxes as a simpler overall method, in the long run, of providing the kind of services that we are advocating.

We recognize that this certainly wouldn't happen overnight. It would take a long time to build up this kind of service, but we feel that this would be a more satisfactory system of paying for the services in the long run.

COMMISSIONER McCUTCHEON: If you recognize a gradual build-up, where would you place your priorities? Should we provide the personnel to do this, or should we put in a scheme and not have the people to operate it?







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Pierce

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4 MR. PIERCE: I think that a number of  
5 things have to move forward at the same time. I think  
6 certainly that one of the areas where we feel an  
7 immediate need is a development of the hospital services  
8 that are now provided through various hospital schemes  
9 in Canada to provide for drugs and prosthetics and  
10 this kind of development, because people definitely are  
11 more prepared, I think, to recognize the need of people  
12 when they are sick than the need for many services which  
13 we would advocate also; in other words, the provision  
14 of mental health services.

15 THE CHAIRMAN: Having made this  
16 recommendation, Mr. Pierce, are you able to give any  
17 recommendation as to its cost?

18 MR. PIERCE: No, I am afraid not. We  
19 really didn't think we were competent to give the cost  
20 of this kind of scheme.

21 THE CHAIRMAN: Have you given any  
22 consideration to an alternative, that those who are able  
23 to pay the premium for themselves should be encouraged,  
24 and so forth, to do so, but those who are not should have  
25 the premiums paid for them, if you accept the proposition  
26 that it is a smaller segment of the community that needs  
27 help rather than the larger segment?

28 MISS TAGGART: Could I speak to this,  
29 Mr. Chairman?

30 THE CHAIRMAN: Yes.

MISS TAGGART: One of the groups that  
concerns us are the people who do pay the premiums but  
where it doesn't cover their need and they don't have



MR. STANLEY: I think that a number of

things have to move forward at the same time. I think

certainly that one of the areas where we feel an

immediate need is a development of the hospital services

that are now provided through various hospital schemes

in Canada to provide for drugs and prosthetics and

this kind of development, because people definitely are

were prepared, I think, to recognize the need of people

when they are sick than the need for many services which

we would advocate also; in other words, the provision

of mental health services.

THE CHAIRMAN: Having made this

recommendation, Mr. Stacey, are you able to give any

recommendation as to its cost?

MR. STANLEY: No, I am afraid not. We

really didn't think we were competent to give the cost

of this kind of scheme.

THE CHAIRMAN: Have you given any

consideration to an alternative, that those who are able

to pay the premium for themselves should be encouraged,

and so forth, to do so, but those who are not should have

the premium paid for them, if you accept the proposition

that it is a smaller segment of the community that needs

help rather than the larger segment?

MR. STANLEY: Could I speak to this,

THE CHAIRMAN: Yes.

MR. STANLEY: One of the groups that

sometimes is the people who do pay the premium but

more it doesn't cover their need and they don't have



Taggart

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4 the finances to take in the slack, and rising up in the  
5 categories depending what the health problem is. It is  
6 another problem of comprehensive care that these sort of  
7 exclusions that you find we would hope would not be  
8 there.

9 THE CHAIRMAN: Well, as in any discussion  
10 we have always got to accept that there is progress in  
11 this field, that the development in the last ten years  
12 has been greater than from the beginning of time. This  
13 is really a developing situation, and only in the last  
14 ten to fifteen years that this type of coverage has become  
15 in any way widespread. The growth has been quite  
16 phenomenal in the last ten years, and the growth in  
17 America has also been the expansion of service.

18 MISS TAGGART: But, nevertheless, our  
19 concern is these people and the needs we see not being  
20 met. You appreciate this, I think.

21 COMMISSIONER VAN WART: Coming back to  
22 the means test, as social workers do you have anything  
23 to do with the application of means tests? It is not  
24 in your activities?

25 MISS TAGGART: I think most of us have  
26 had some experience in it.

27 THE CHAIRMAN: You would try to separate  
28 it from your work as social workers?

29 MISS TAGGART: No, not necessarily.

30 MISS MICHAUD: Maybe we should clarify  
that. In hospitals, whenever they establish a social  
service department, since they already have the machinery  
to have the clinic, they don't expect that department to





the finances to take in the slack, and rising up in the  
 categories depending what the labor problem is. It is  
 another problem of comprehensive care that these sort of  
 exonerations that you find we would hope would not be  
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 this field, that the development in the last ten years  
 has been greater than from the beginning of time. This  
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 ten to fifteen years that this type of coverage has become  
 in any way widespread. The growth has been quite  
 phenomenal in the last ten years, and the growth in  
 America has also been the expansion of service.

MRS. TAYLOR: But, nevertheless, our  
 concern is these people and the needs we are not being  
 met. You approximate this, I think.  
 MRS. TAYLOR: You want to bring back to  
 the means test, as social workers do you have anything  
 to do with the allocation of means tests? It is not  
 in your activities.  
 MRS. TAYLOR: I think most of us have  
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THE CHAIRMAN: You would try to approximate  
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 service department, since they already have the machinery  
 to have the clinic, they don't expect that department to



Taggart

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4 take the responsibility? You have individuals who have  
5 responsibility, directly or indirectly, to do with the  
6 regulations. .

7 COMMISSIONER VAN WART: In carrying  
8 out the procedures for the means test do you meet  
9 resistance from the people or are they co-operative?

10 MISS TAGGART: I would say on the whole  
11 they co-operate. It makes a very real difference how  
12 you administer a means test and you do it in a way  
13 whether you respect the person or whether you treat them  
14 as a second class person. A good many private social  
15 agencies charge fees, and this involves some assessment  
16 of the person's ability to pay for service.

17 COMMISSIONER McCUTCHEON: In your  
18 work you apply means tests every day?

19 MISS TAGGART: Yes.

20 COMMISSIONER VAN WART: And you find  
21 co-operation?

22 MISS TAGGART: Yes, very definitely.

23 THE CHAIRMAN: Thank you very much  
24 for your attendance here, and we wouldn't want you to  
25 misunderstand the nature of the questioning. We are  
26 trying to find out because we have invited a number of  
27 welfare organizations to come so that we may have this  
28 type of information from them, not just theoretical but  
29 from the people who are actually working with this class  
30 of people, and to see just what the reaction is in terms  
of this matter of means tests and qualifications, and  
so forth, of various things. So we want you to feel  
that we are obliged to you for your attendance here and



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you administer a means test and you do it in a way  
whether you respect the person or whether you treat them  
as a second class person. A good many private social  
agencies charge fees, and this involves some assessment  
of the person's ability to pay for services.

COMMISSIONER HODGKINSON: In your

work you employ means tests every day?

MR. TAPPAH: Yes.

COMMISSIONER VAN WART: And you find

co-operation?

MR. TAPPAH: Yes, very definitely.

MR. CLARK: Thank you very much.

for your attendance here, and we wouldn't want you to  
misunderstand the nature of the question. We are  
trying to find out because we have indicated a number of  
welfare organizations to come so that we may have this  
type of information from them, not just theoretical but  
from the people who are actually working with this class  
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of this matter of means tests and co-operation, and  
of course, of various things. So we want you to feel  
that we are obliged to you for your attendance here and





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Taggart

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for the information in your brief and for your willingness to discuss the problems as frankly as you have done this afternoon. Thank you.

MISS DENAULT: We are very thankful also for your hearing. We appreciate it is not very often that we have the opportunity of airing views.

THE SECRETARY: The next submission is from the Young Women's Christian Association of Canada, Exhibit 331. Miss Vuchnich will introduce the group.

EXHIBIT NO. 331:

Submission of the Young Women's Christian Association of Canada.



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to discuss the problem as frankly as you have done  
this afternoon. Thank you.

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also for your hearing. We appreciate it is not very often  
that we have the opportunity of giving views.

THE SECOND: The next submission is  
from the Young Women's Christian Association of Canada,  
which is...

Submission of the Young  
Women's Christian Association  
of Canada.

WINTER 1931



11632

SUBMISSION OF  
YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF CANADA

APPEARANCES: Mrs. M. Vuchnich  
Mrs. P. Chadsey  
Mrs. A.G. Wright  
Miss Agnes Roy

MRS. VUCHNICH: Mr. Chairman, on my left is Mrs. Phillip Chadsey, Chairman of the Public Affairs Committee; on my right Mrs. A.G. Wright, of the Metropolitan Toronto Y.W.C.A., and Miss Agnes Roy, Executive Director of the Y.W.C.A. of Canada.

Mr. Chairman, we have a brief statement.

Mr. Chairman, members of the Commission, the YWCA of Canada appreciates greatly the privilege of making this submission to you. Our brief has been submitted to your for previous consideration as you requested and therefore at this time I should like to make only a short statement.

Our brief makes only one recommendation, namely, that the Government of Canada endeavour to reach agreement with all provincial governments and with the Canadian Medical Association to ensure progressive implementation of a comprehensive national plan of health services to all residents of Canada.

We have submitted this brief at the direction of our last quadrennial Convention. Our membership is composed largely of women with incomes which would not easily cover sudden or large medical expenses, but who are anxious to make such payments as possible. In the opinion of our members and for such





CONFERENCE OF THE CANADIAN MEDICAL ASSOCIATION

AGENDA:  
 Mrs. M. W. Nicholson  
 Mrs. P. Chabrey  
 Mrs. A. W. Wright  
 Mrs. A. W. Wright

MRS. WILKINSON: Mr. Chairman, on my left is Mrs. Philip Chabrey, Chairman of the Public Affairs Committee; on my right Mrs. A. W. Wright, of the Metropolitan Toronto Y.W.C.A., and Mrs. Agnes Ray, Executive Director of the Y.W.C.A. of Canada.

Mr. Chairman, we have a brief statement.

The Y.W.C.A. of Canada appreciates greatly the privilege of making this suggestion to you. Our brief has been submitted to your previous consideration as you requested and therefore at this time I should like to make only a short statement.

Our brief makes only one recommendation, namely, that the Government of Canada endeavor to reach agreement with all provincial governments and with the Canadian Medical Association to enable progressive implementation of a comprehensive national plan of health services to all residents of Canada.

We have submitted this brief to the direction of our last International Convention. Our membership is composed largely of women. The fact that it would not easily cover such an extensive field of expenses, and who are anxious to make such payments as possible. In the opinion of our members, it is not



Vuchnich

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4 reasons as are set forward in the brief, a comprehensive  
5 national plan is the best method of securing optimum  
6 health care for all Canadians.

7 We should like to emphasize that we  
8 do not feel qualified to make any but general observations  
9 on the administration or financing of such a plan. Our  
10 submission is made solely out of our concern for the  
11 needs of the Canadian people. We realize the problems  
12 and the cost involved in carrying out a national health  
13 plan and it is for that reason that we have recommended  
14 a progressive implementation.

15 THE CHAIRMAN: Thank you, Mrs. Vuchnich.  
16 What do you mean by "comprehensive national plan"?

17 MRS. VUCHNICH: We have set forth in  
18 our brief -- Mrs. Chadsey, would you like to speak to  
19 that?

20 MRS. CHADSEY: I think, Mr. Chairman,  
21 we mean a national plan covering all residents of Canada  
22 regardless of their ability to pay.

23 THE CHAIRMAN: When you use the word  
24 "national", is there anything particular about it?

25 MRS. CHADSEY: National in the sense  
26 that it covers all residents of Canada. You meant national  
27 in its administration?

28 THE CHAIRMAN: Yes.

29 MRS. CHADSEY: I think probably, Mr.  
30 Chairman, we would recognize the fact that the provinces  
have the authority in health matters and that would  
continue, but presumably with some federal assistance.

THE CHAIRMAN: That would be the



persons as are set forth in the brief, a comprehensive  
national plan is the best method of securing optimum  
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do not feel qualified to make any but general observation  
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submission is made solely out of our concern for the  
needs of the Canadian people. We realize the problems  
and the cost involved in carrying out a national health  
plan and it is for that reason that we have recommended

THE CHAIRMAN: Thank you, Mrs. Wuchitch.  
What do you mean by "comprehensive national plan"?

MRS. WUCHITCH: We have set forth in  
our brief -- Mrs. Chabsey, would you like to speak to  
that?

MRS. CHABSEY: I think, Mr. Chairman,  
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regardless of their ability to pay.

THE CHAIRMAN: When you use the word  
"national", is there anything particular about it?

MRS. CHABSEY: National in the sense  
that it covers all residents of Canada. You want national  
in the administration?

THE CHAIRMAN: Yes.

MRS. CHABSEY: I think, probably, Mr.  
Chairman, we would recognize the fact that the provinces  
have the authority in health matters and that would  
continue, but possibly with some federal assistance.  
THE CHAIRMAN: That would be the





Vuchnich

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4 assumption. So that you would have basically, you might  
5 have basically ten plans?

6 MRS. CHADSEY: You might have basically  
7 ten plans, yes.

8 THE CHAIRMAN: Various provinces haven't  
9 been too easy to be herded into one stall on pretty well  
10 anything. From your experience, what would you say or  
11 are in a position to say what is the most immediate  
12 need in health services? You are speaking of a progressive  
13 plan?

14 MRS. CHADSEY: Yes, I see what you  
15 mean. I suppose on practical terms that would depend  
16 at what province you would aim.

17 THE CHAIRMAN: Let's stay in Ontario.

18 MRS. CHADSEY: In Ontario, those  
19 services on the list which we have given on page 4 of the  
20 summary, paragraph 10. In-patient hospital services  
21 are already covered by the hospitalization plan in  
22 Ontario, and we would include such services of immediate  
23 necessity of medical fees, drugs and diagnostic and  
24 laboratory services as are not already covered under the  
25 plan.

26 THE CHAIRMAN: You are concerning  
27 yourself basically with the physician services for the  
28 average patient?

29 MRS. CHADSEY: That is assuming that  
30 the hospital care is already taken care of.

THE CHAIRMAN: Yes, over and above  
hospitals.

MRS. CHADSEY: Yes.



assumption. So that you would have basically, you might

MRS. CHAIRMAN: You might have basically  
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at what province you would aim.  
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summary, paragraph 10. Inpatient hospital services  
are already covered by the hospitalization plan in  
Ontario, and we would include such services of immediate  
necessity of medical tests, X-rays and diagnosis and  
laboratory services as are not already covered under the  
plan.

THE CHAIRMAN: You are concerning  
yourself mainly with the physician services for the  
average patient?  
MRS. CHAIRMAN: That is all right, that  
the hospital care is already covered under the  
plan, over the above  
services.



Chadsey

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4 THE CHAIRMAN: Have you any views as  
5 to whether, being able to do so much and no more, on the  
6 situation in regard to, say, those suffering from mental  
7 illness, mental retardation, crippling diseases?

8 MRS. CHADSEY: At the top of the  
9 services in that same paragraph, paragraph 10 it says:

10 "It is important that these services  
11 "cover both mental and physical illness".

12 THE CHAIRMAN: But I mean to say, do  
13 you think that of the two -- that they are being taken  
14 care of equally now?

15 MRS. CHADSEY: No.

16 THE CHAIRMAN: Which one would you go  
17 forward in, then?

18 MRS. CHADSEY: I suppose we would say  
19 that the first need is to bring the mental services up  
20 to the other services and then the two should go forward  
21 side by side.

22 THE CHAIRMAN: Bring the mental service  
23 up to the level of physical service?

24 MRS. CHADSEY: Yes.

25 COMMISSIONER VAN WART: Do you feel  
26 that this should be under a premium system or under a  
27 government scheme?

28 MRS. CHADSEY: We have considered this  
29 matter, and we don't feel we are qualified to give  
30 details on any costs. But I think as a general opinion  
we would prefer the method of income tax assessment as  
being fairer to the average person in assessing their  
ability to pay. But we also realize that in certain





THE CHAIRMAN: Have you any ideas as to whether, being able to do so much and no more, on the situation in regard to, say, those suffering from mental illness, mental retardation, spinning diseases?

MRS. CHADWICK: At the top of the services in that same category, perhaps 10 it says: "It is important that the services

"cover both mental and physical illness."

you think that of the two -- that they are being taken care of equally now?

THE CHAIRMAN: Which one would you go forward in, then?

MRS. CHADWICK: I suppose we would say that the first need is to bring the mental services up to the other services and that the two should go forward side by side.

THE CHAIRMAN: Would you like to bring the mental services up to the level of physical services?

MRS. CHADWICK: Yes.

COMMISSIONER VAN WATTE: Do you feel that this would be under a similar system on which a government agency?

MRS. CHADWICK: We have some other things, and we don't feel we are qualified to give opinions on any costs. But I think as a general opinion we would, under the sort of income tax also sent an amount, either to the average person or assisting their ability to pay, but we also realize that in certain



Chadsey

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4 cases the premium method is a great deal more practical,  
5 and therefore I don't think we are in a position to  
6 express any hard and fast opinion.

7 COMMISSIONER VAN WART: Those people  
8 who can afford to pay the premium, have you any objections  
9 to having an insurance scheme, voluntary insurance  
10 scheme for these people?

11 MRS. CHADSEY: And thus excluding a  
12 government scheme? Yes, I think we would object to that.  
13 We would prefer a national scheme.

14 COMMISSIONER VAN WART: On what do you  
15 make your objections?

16 MRS. CHADSEY: Largely on the principle,  
17 I think, that voluntary schemes, as they have shown  
18 themselves, tend to be exclusive of too many people for  
19 various reasons. Would you agree with that, Mrs. Wright?

20 MRS. WRIGHT: Yes, I think we would  
21 feel that in our objection to the voluntary plans,  
22 speaking generally, is their limitations and limitations  
23 of benefits and the exclusiveness of enrolment in some  
24 cases, and we feel that the limitation of benefits can  
25 seriously cripple people who, in the ordinary course of  
26 life, are able to look after their commitments and  
27 in this case do all they can to look after them.

28 THE CHAIRMAN: Supposing these limita-  
29 tions, whether they are going to be on a national plan  
30 or in some other limitations which are man-made--it is  
a matter of writing them into a contract or into  
regulations or into a statute-- but supposing this matter  
of limitations was eliminated, that you could get a



cases the present method is a great deal more practical,  
and therefore I don't think we are in a position to  
express any kind of objection.

COMMISSIONER VAN WAGEN: These people  
who can afford to pay the premium, have you any objection  
to having an insurance scheme, voluntary insurance  
scheme for these people?

MRS. GLADLEY: And this excluding a  
government scheme? Yes, I think we would object to that.  
We would prefer a national scheme.

COMMISSIONER VAN WAGEN: On what do you  
base your objection?

MRS. GLADLEY: Largely on the principle  
I think, that voluntary schemes, as they have shown  
themselves, tend to be exclusive of too many people for  
various reasons. Would you agree with that, Mrs. Wright?

MRS. WRIGHT: Yes, I think we would  
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of benefits and the exclusiveness of enrollment in some  
cases, and we feel that the limitation of benefits can  
seriously exclude people who, in the ordinary course of  
life, are able to make a few their commitments and  
in this case do all they can to live after that.

MR. CHAMBERLAIN: Suggesting these limita-  
tions, whether they are going to be on a national plan  
or on a local plan, which are voluntary--is it  
a matter of limiting them into a certain or into  
a certain or into a certain--but suggesting this matter  
of limitations are all mixed, that you don't get a





Chadsey

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4 broad coverage, do you still think that the voluntary  
5 idea is wrong?

6 MRS. VUCHNICH: No, we don't think the  
7 voluntary idea is wrong. I think the thing we would  
8 want to protect is that there would be health services  
9 available for all Canadians. This is the basis on which  
10 we have moved.

11 THE CHAIRMAN: Why do you say that?  
12 Just why do you say there should be health services  
13 available for all Canadians? I mean, is it something  
14 like saying we should all live in the most salubrious  
15 climate in the world?

16 MRS. CHADSEY: I think the trouble  
17 with voluntary plans from our point of view is that they  
18 tend to exclude a number of people who, for one reason  
19 or another, do not join the voluntary plans.

20 THE CHAIRMAN: Do not of their own  
21 free will? a compulsion in one important respect of the

22 MRS. CHADSEY: Of their own free will.

23 THE CHAIRMAN: All right, shouldn't  
24 they have that privilege?

25 Chairman. MRS. CHADSEY: If they have not --

26 THE CHAIRMAN: If I don't want to wear  
27 a hat I can go around bareheaded.

28 MRS. CHADSEY: I think we would say  
29 from our experience that in many cases it is not indifference  
30 to the scheme or indirect opposition to the scheme, it  
31 is a lack of knowledge that prevents them from joining.

32 THE CHAIRMAN: And supposing that  
33 knowledge can be brought home to them. All I am suggesting



Chairman

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THE CHAIRMAN: No not of them, are  
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MRS. CHASE: Of their own free will.  
THE CHAIRMAN: All right, shouldn't  
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MRS. CHASE: If they have not ---  
THE CHAIRMAN: If I don't want to wait  
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THE CHAIRMAN: And according to  
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Chadsey

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4 to you, has your thinking gone far enough that you must  
5 necessarily choose the compulsory road if the voluntary  
6 road was available with improvements?

7 MRS. VUCHNICH: Well, what improvements?

8 THE CHAIRMAN: All kinds of improve-  
9 ments. Have you just made a decision for compulsion as  
10 a matter of principle?

11 MRS. CHADSEY: No, Mr. Chairman, I  
12 don't think we have. I think we have made that decision  
13 because, as far as we can see, we feel that the compulsory  
14 system serves a greater number of Canadians.

15 COMMISSIONER McCUTCHEON: By compelling,  
16 serving a greater number of Canadians by compelling.  
17 That is the essence of compulsory I guess.

18 THE CHAIRMAN: In this field.

19 MRS. CHADSEY: In this field, yes.

20 THE CHAIRMAN: There are those who say  
21 if you have compulsion in one important segment of the  
22 life of a community it is just a step to compulsion in  
23 another segment.

24 MRS. CHADSEY: Well, not necessarily,  
25 Mr. Chairman. I think that compulsion in this sense is  
26 compulsion in the sense that it is a compulsion laid  
27 on by the people themselves inasmuch as this plan is  
28 not going to be accepted unless it is acceptable to the  
29 people. So they are in a sense agreeing there.

30 THE CHAIRMAN: Would those rendering  
this service be under similar compulsion?

MRS. CHADSEY: You mean in as far  
as doctors wouldn't be permitted private practice?





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and as you see we are still a compulsion?

MRS. GARDNER: You mean in as far

as compulsion wouldn't be permitted private practice?



Chadsey

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4 I think we would agree that if the services were  
5 adequately rendered we would not envisage compulsion  
6 on the part of people who were giving the services.

7 COMMISSIONER BALTZAN: Hypothetically  
8 speaking, purely hypothetically, supposing people had  
9 enough money to pay for the kind of services they needed,  
10 if and when they needed it, would you still advocate a  
11 nationally-operated health plan?

12 MRS. CHADSEY: You mean if everybody --

13 THE CHAIRMAN: National in the sense  
14 you have mentioned. I don't think you should put in the  
15 connotation that you want this run from Ottawa.

16 MRS. CHADSEY: You mean if everybody  
17 was able to pay?

18 COMMISSIONER BALTZAN: A government-run  
19 plan.

20 MRS. CHADSEY: I hardly think that that  
21 applies in this instance. It seems to be highly  
22 unlikely.  
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nationally-operated health plan?

MR. CHAFFET: You mean if everybody -

THE CHAIRMAN: National in the sense

you have mentioned. I don't think you should put in the

connection that you want this out from Ottawa.

MR. CHAFFET: Not even if everybody

was able to pay?

COMMISSIONER BAILEY: A government-run

MR. CHAFFET: I hardly think that that

applies in this instance. It seems to me highly

unlikely.





Vuchnich

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COMMISSIONER BALTZAN: I am putting  
a hypothetical question.

MRS. VUCHNICH: I would doubt if that  
problem would ever have arisen as a problem to our  
members if we could envisage everyone being able to pay.

THE CHAIRMAN: We will have to wait  
for the millenium.

COMMISSIONER BALTZAN: The reason I  
put that question, whether it is actually a question  
of service or a question of dollars that bothers  
people so much.

COMMISSIONER VAN WART: Your work  
takes you into the lower income bracket, it is not the  
true indigent and it is not the welfare group; it is  
more the group that become, as we call them, medically  
indigent. That is, when they get sick they have not  
the means to finance their illnesses. Having that in  
mind, you bring up your solution; well, if another  
solution was brought forward which would give medical  
care without financial difficulty to this group you  
would be perfectly satisfied, would you?

MRS. VUCHNICH: Yes, I would think so.

THE CHAIRMAN: In your own work you  
render service?

MRS. VUCHNICH: Yes.

THE CHAIRMAN: For some of these  
services you receive some payment from those to whom  
you render the service and for other services you do  
it voluntarily? Now, is there another area where you  
are paid according to the ability of the person to pay?



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Vuchnich

11641

MRS. VUCHNICH: Are you speaking of services which the Y.W.C.A. renders to people?

THE CHAIRMAN: Yes.

MRS. VUCHNICH: I think one example of this would be in the counselling services in the large cities, the large associations where we have them where people are definitely charged on a sliding scale based on ability to pay from nothing to a maximum.

THE CHAIRMAN: And do you find any great difficulty in working out that system?

MRS. VUCHNICH: Not too much difficulty. I think there was a great deal of difficulty in working it out in the beginning and accepting a principle.

THE CHAIRMAN: But once being accepted the principle, in its day-to-day operation, discussing whether Miss X or Miss Y will pay the full or half the amount, do you find it very difficult to make that decision?

MRS. VUCHNICH: I think this would be something between Miss X and the individual counsellor. I must say we are talking about a very small segment of the Y.W.C.A. population. For most of our services there would be a fixed charge or none. This would be the one with a sliding scale.

THE CHAIRMAN: Would you have cases where, in the residences, you might have a different scale?

MRS. VUCHNICH: Yes.

COMMISSIONER McCUTCHEON: You can apply the means test without too much difficulty?





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THE CHAIRMAN: Would you have cases

where, in the instances, you might have a different

MRS. VUCHNICH: Yes.

THE CHAIRMAN: How would you

apply the means test without too much difficulty?



Vuchnich

11642

MRS. VUCHNICH: Yes.

COMMISSIONER McCUTCHEON: And you recognize there are circumstances in which means tests are necessary?

MRS. CHADSEY: Oh, I think we would recognize that.

MISS ROY: But it is in giving service that people are coming too for a variety of reasons. I think there is an element in this health problem that is a pretty serious one for people and I would think that the whole procedure necessary to the application of a means test when the illness is the factor would be a much more difficult one to administer than the young woman who goes into the Y.W.C.A. wanting a place to live.

THE CHAIRMAN: Yes, but if we apply it from another angle on the prepayment basis where it is a question of premium which you pay, whether you are ill or healthy, and you do not have to wait until you become ill to have a discussion with anybody or with a year's premium, you do it automatically and most likely when you are well so you would see a little difference there.

I can see that waiting until a person was sick and then having to go when you have a splitting headache and have some discussion about whether you pay or not, it would be quite irritating, at least it would be to me.

COMMISSIONER BALTZAN: It might even aggravate the headache.



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190. Mr. ROY: Yes.

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191. Mr. ROY: Oh, I think we would

192. Mr. ROY: But it is in giving services

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193. THE CHAIRMAN: Yes, but if we apply it

from another angle on the payment basis where it is

a question of premium which you pay, whether you are

ill or healthy, and you do not have to wait until you

become ill to have a discussion with anybody or with a

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was sick and then having to go when you have a definite

condition and have some discussion about whether you pay

or not, it would be quite irritating, at least it would

be to me.

194. THE CHAIRMAN: Well, it isn't even

195. Mr. ROY: The health insurance





Vuchnich

11643

THE CHAIRMAN: I am talking in terms of the subsidized premium to those who are unable to pay the whole premium or part of it. Would you, from your experience, see that as something that was unworkable?

MRS. VUCHNICH: Not necessarily.

THE CHAIRMAN: That is the reason we put the proposition that before a person would necessarily accept a compulsory scheme, is there anything wrong with looking at every phase of trying to make the voluntary proposition work if it is possible to make it work effectively and efficiently?

MRS. WRIGHT: May I say I think there is this tremendously important point; that the coverage given by the voluntary ---

THE CHAIRMAN: We have to accept that completely, that the coverage would have to be broad enough so that nobody would fall down.

MRS. WRIGHT: I apologize for stressing it.

THE CHAIRMAN: No reason to apologize at all. You are here as women interested in the welfare of other citizens and with no axe to grind for yourselves. We recognize this, that you are a voluntary organization.

COMMISSIONER McCUTCHEON: An example of a voluntary system at work.

COMMISSIONER VAN WART: You would not want your Y.W.C.A. to be done away with under the system, would you?

MRS. VUCHNICH: No.



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THE CHAIRMAN: I am talking in terms of the subsidized premium to those who are unable to pay the whole premium or part of it. Would you, from your experience, see that as something that was unworkable?

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THE CHAIRMAN: We have to accept that completely, that the coverage would have to be broad enough so that nobody would fall down.

MRS. WRIGHT: I apologize for interrupting.

THE CHAIRMAN: No reason to apologize at all. You are, too, as women interested in the welfare of the community, and you are a voluntary organization. We recognize this, that you are a voluntary organization.

CONGRESSIONAL COMMITTEE: An example of a voluntary system at work.

CONGRESSIONAL COMMITTEE: Yes, it is not that you are to be done away with when the system would work.

MRS. WRIGHT: Yes.



11644

THE CHAIRMAN: So it is because of your interest, your experience and the fact that you have no particular axe to grind that we are very happy to have had you here and have had your views and your brief for which we are very grateful. Thank you very much.

We will take a short recess and then proceed.

--- Short Recess





THE CHAIRMAN: It is a pleasure  
your interest, your experience and the fact that you  
have no particular axe to grind that we are very happy  
to have had you here and have had your views and  
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proceed.



THE CHAIRMAN: We will come to order and proceed.

SUBMISSION OF DR. K.J.R. WIGHTMAN AND

DR. R. FARQUHARSON.

THE CHAIRMAN: You gentlemen have no written brief?

DR. FARQUHARSON: That is right.

THE CHAIRMAN: Except an invitation was extended to you to discuss one element of the topic before us in the matter of the prescription drugs?

COMMISSIONER McCUTCHEON: Dr. Farquharson, we have heard a great deal, as you might imagine, about the rapid introduction of new drugs during the past years since the war, the late stages of the war. We have heard a great deal about the high cost of drug therapy. We have had some evidence that in any comprehensive national health scheme it has been necessary to restrict the list of drugs that is provided, restrict the quantities, restrict the number of times a prescription can be refilled and/or to impose utilization charges at the time of the prescription.

We have also had evidence to indicate that even with that type of legislation there has been a tendency for drug costs to mount. We were told by one physician a day or two ago who practised for several years under the British National Health Scheme that his great occupation was writing out prescriptions for



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THE CHAIRMAN: We will come to order.

and proceed.

THE CHAIRMAN: You gentlemen have no

DR. PARSONSON: That is right.

THE CHAIRMAN: Except an invitation

was extended to you to discuss one element of the

topic before us in the matter of the prescription

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COMMISSIONER MONTGOMERY: Dr. Parson-

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the physician a day or two ago who pointed out several

years under the United States National Health Insurance Act

the great contribution was writing out prescriptions for





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TORONTO, ONTARIO

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3 whatever the patient wanted. He spoke of the pressure  
4 on the physician. Would you care to make a general  
5 statement and then possibly the subject will develop?  
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DR. FARQUHARSON: In general, the administration of drugs falls into three or four different classes or situations. We have the drugs that are needed for acute illnesses, most of which when severe are treated --- most of the patients when their illness is severe, are treated in hospitals.

Their drugs are supplied by the hospital Commission in all our provinces free of charge, part of the hospitalization scheme and then one relies on the good judgment of the doctors as to what drugs to use and how long to give them, but they are limited by their stay in the hospital and the problem of doing harm, while it always arises with any new drug, does not exist for very long.

Then there is the problem of the drugs that are needed for a long continued use, which must be available to all if we are to treat these people well.

COMMISSIONER McCUTCHEON: For example?

DR. FARQUHARSON: Diabetes. Another example for a shorter period of time, the treatment of tuberculosis with the new drugs which have proven so wonderfully effective which usually goes on for one or two years, and again is usually done in our hospitals for the tuberculosis patients but is sometimes done at home and should be supplied.

There are drugs that are not so expensive, although some of them are fairly expensive for the treatment of patients suffering from deficiencies, such as deficiency of the thyroid gland when thyroid must be continued for a long time, diabetes and insulin.



classes or situations. We have the drugs that are needed for acute illnesses, most of which are severe and treated -- most of the patients with these illnesses are severe, are treated in hospitals.

Their drugs are supplied by the Hospital Commission in all our provinces free of charge, part of the hospitalization scheme and then one has to see the good judgment of the doctor as to what drugs to use and how long to give them, but they are limited by their stay in the hospital and the problem of doing them, while it always comes with any new drug, does not exist for very long.

Then there is the problem of the drugs that are needed for a long continued use, which must be available to all if we are to treat these people well.

COMMISSIONER OF HEALTH: For example,

Dr. WILKINSON: Of course, a number

examples for a shorter period of time, the treatment of tuberculosis with the new drugs which have proven so wonderfully effective which usually goes on for one or two years, and again is done in our hospitals for the tuberculosis patients but is not done at home and would be supplied.

There are also at one time so expensive

one, although some of them are fairly expensive, on the treatment of patients suffering from certain diseases, and at the same time the trouble of the patient's family and the patient's family.



Farquharson 11648

Deficiency of the adrenal gland, a much rarer condition for which cortisone is a specific remedy.

Cortisone should be supplied for those people indefinitely. If they go a few days without cortisone, they become very ill and may die.

Then there are a number of new, expensive drugs that are needed for long continued use in such conditions as chronic heart failure with great swelling of the tissues where people need some --- many of the newer diuretics and drugs of that kind are sometimes needed to be kept up for a long time and it taxes the situation when people are not well enough off.

I think that it is important to have facilities to make such drugs available to all that need them. Then there come the great group of drugs to which I think you are referring, and particularly the new and the very expensive drugs. They are being introduced with great frequency. They are coming so quickly that doctors in general cannot understand their use thoroughly and have to get information about them by experience and most of these drugs are potentially harmful, as well as often being very good and very effective when used in the right place.

It is unfortunate that there are many patients who like to be taking the newest drugs, and many patients try to get new drugs from their doctors, new and expensive drugs, even when the doctors do not wish to give them. They go from one doctor to another until they get one who will give them a prescription for these drugs.



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Farquharson 11649

There is not, I think, any instance of any of the newer and extremely potent and very effective drugs, if effective in certain situations, that is not capable of doing a great deal of harm, fortunately much less commonly.

I think that it would be a bad thing to make these drugs freely available without charge to all who wish to use them. Most of the doctors can be trusted to use them well. There are some doctors who always like to be using the latest remedy. A natural thing. They want to learn more about it. Unless they use them with great care, they may give rise to serious harm.

The newspapers have noted many instances of this over the years and particularly the drug you have all heard of that would lead, when given as a sedative to pregnant women, would lead to deformities, very serious deformities in the developing child.

I think that it is better that these drugs should not be supplied at no cost to the patient. I think that nothing should be done to increase their use until they are thoroughly established. It is true that sometimes it takes a long period of use to find the harmfulness with newer remedies.

Dr. Wightman has been particularly interested in this special problem for the last fifteen or more years and I think can speak to it more effectively than I can.

There is one other type of drug that I would like to mention that I think should not be on any



There is not, I think, any instance  
of any of the newer and extremely potent and very effec-  
tive drugs, in effective in certain situations, that is  
not capable of doing a great deal of harm, fortunately  
such cases commonly.

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There is one other point of view that  
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Farquharson 11650

free list, and that is the commonly used sedative. It is one of the faults of our civilization in North America, and in many other parts of the world, that far too many sedatives are taken and it is not an uncommon thing at all for a patient to go to one doctor for a prescription, and to another doctor for a prescription, each doctor not knowing that the other has given it and many times people get large amounts of sedatives in this way that are doing them --- failing to do them any good and often doing them a great deal of harm. One could elaborate on similar situations, but I think those are clear examples.

COMMISSIONER McCUTCHEON: We are becoming people who are busy prescribing for ourselves out of the Reader's Digest and then insisting that the doctor treat us accordingly.

DR. FARQUHARSON: There is that. The doctor sees many instances of that kind of thing. Patients come into his office and ask -- patients in all ranks of society, and ask for a special preparation and are often very much annoyed if he does not think that it is in their interest to have them. I must admit that once in a while he knows about it and its value before the doctor does, but it works both ways sometimes, but the problem is very much that way.

COMMISSIONER BALTZAN: He wishes that he had read the article in Reader's Digest.

DR. FARQUHARSON: Sometimes he has not kept up.

COMMISSIONER McCUTCHEON: Dr. Wightman,







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would you like to say something?

DR. WIGHTMAN: I would support what Dr. Farquharson has said. I think there are various ways of classifying the problem in terms of what kinds of drugs there are. I think one could divide them into those that are specific remedies which are curative medication which actually strike at the cause of a disease and do something which brings about a cure, and then there are the others which are remedies of various sorts, some of which merely cover up the symptoms of a disease or disorder without doing anything to strike at its cure.

There are others, the third class sort of patches up the disturbance or function that is present because of the disease by making various organs work overtime or stimulating their effect. They are useful in the kind of things, the diuretics that was mentioned which makes the patient get rid of salt and water because the heart is not doing its job. Makes the kidneys work overtime to try and compensate, so I think if you regard them in these various categories it would seem sensible to make sure that any remedy which was a cure, or which was a specific remedy, even if it was not a cure, it provides what the patient needed, to replace the function of an organ.

Any one that acts in this third category, which was to compensate, if you like, for the patient's deficiencies in organ function, those are the most important ones. This other group, the one which gives the most problem really, is this group that you can



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patient's deficiencies in organ function, those are the  
rest of the remedies. The other group, the one which  
brings the organ back to its normal function, is the group that you





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get along without, which you can use old remedies almost as well as new ones which are merely symptomatic therapy.

COMMISSIONER McCUTCHEON: How much of that is there? What per cent of your drug bill is in that class? Would you like to put a figure on it?

DR. WIGHTMAN: The figure would not mean anything. You have more figures at your disposal than I have, I am sure, but when one considers the amount of money that the public spends on vitamins and self-medication and drugs that do not need to be prescribed, and if you add to that the amount that is spent on symptomatic remedies, I think this would be the greater part of the whole by quite a large amount.

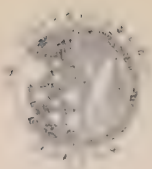
COMMISSIONER McCUTCHEON: Would you limit it a little bit? Keep it out of say, the self-medication and vitamins, things that you can go in and buy yourself. On prescription drugs alone would you care to make any statement as to whether we are being over-drugged or under-drugged?

DR. WIGHTMAN: A guess would be that in this area of symptomatic therapy, that there is too much being used. I would not be at all surprised to find it was more than half the drug bill, but that is a guess.

COMMISSIONER BALTZAN: Over-used or over-prescribed?

DR. WIGHTMAN: Well, I suppose most of them can only be obtained on prescription, so we must assume ----

COMMISSIONER McCUTCHEON: We are talking only about the drugs on prescription.



11552 Wightman

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DR. WIGHTMAN: We see in hospitals, if you go over the drug lists, and I used to do this every week, go over the cards, tells you what medications, and strike-off the ones that you do not think are necessary, it's always quite a list of them.

COMMISSIONER BALTZAN: Dr. Wightman, what is the compelling force in this business of over-prescribing, if you want to call it over-prescribing, or the supplying of more than a minimum amount for a sufficient length of time, and so on. What is the compelling force?

DR. WIGHTMAN: Well, I think there are several compelling things. I think the first situation that this happens in is the situation where you have not much else to offer the patient. In other words, the patient comes to you with complaints which you feel are perhaps rooted in some sort of psychological disturbance, or in his constitution or in a variety of things that add up to a situation for which there is no immediate cure and so you find yourself doing something to alleviate what the patient is complaining of. To make him suffer less, if you like, and you may do this with drugs that have no effect at all. Of course, those placebos will often relieve such patients.

A doctor feels a certain loss of self-respect if he gives placebos very often, I think. He is perhaps as hopeful that some of the claims for these new drugs are accurate as the maker of them is. He often wishes to try these things because of this situation that he finds himself in. I think that it is very hard under those circumstances to be sure if the patient improves,





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Wightman 11654

what it was that made him improve, but it is easy enough to build up a faith in a drug. I know you have seen this happen, and to use it more and more and more and eventually after a few years his faith dwindles and the drug falls into the discard and a new drug comes along. I think this is the most concern of this sort of thing. Some of it is the patient's demand, as has been stated.

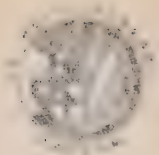
On the other hand, we encounter a fair number of patients who are frightened of drugs and who object to taking drugs and you have to persuade them, when you think in your own mind they really should take them. They are both sides of that question.

COMMISSIONER BALTZAN: Is the thing that is known in medicine true that 30% of the times that you prescribe a drug, say one-third, whether actual specific amounts, that in 30% of the cases because he has taken a drug or a medicine the patient feels better?

DR. WIGHTMAN: Yes. This is true of a wide variety of diseases. It is not true of pernicious anemia. You have to have the right drug there before you feel better. Various diseases in which a specific remedy, as I have called them, take effect, an immediate almost invariable effect.

You can be very sure of most of those other diseases which include angina pectoris, Parkinson's disease, rheumatoid arthritis. All sorts of things which are really diseases and an ineffective remedy, a remedy with no meat in it, if you like, can produce improvement in as many as 30% of patients.

COMMISSIONER BALTZAN: Not improvement



11884 Wightman

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function symptom.



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Wightman

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COMMISSIONER McCUTCHEON: Dr. Farquharson mentioned when he was speaking a few minutes ago that you might say something on this question of the length of time it took to establish that drugs didn't have harmful side effects. I think he suggested you might give us some examples.

DR. WIGHTMAN: Well, there are some very interesting examples. One of the commoner drugs that is used very frequently without a doctor's prescription is phenacetin. It is one of the drugs in 222. It has been in use for more than 40 years, and at this time now we are beginning to realize that this drug may have effects on the patient's kidneys and on his blood, and perhaps on other parts of his body, which were never appreciated until quite recently.

It is true that the patients in whom we see this are patients who are taking far more of these pills than we ordinarily want them to, or suggest, but nevertheless, here is a toxic effect that has gone on for more than 40 years.

The new drugs have been tested on animals, but there are always side effects which you cannot determine on animals, whether you give it to an animal for days or weeks or in big doses or in little doses. It still has to be exposed to a number of human beings and the length of time it takes depends on the number of times it is exposed.

If it is very popular and hundreds of thousands of people take it, its toxic effect may become evident in a couple of years. It depends how





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Wightman

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definite that is, or how obvious it is. It may be a subtle thing that is hard to recognize.

One of the first drugs to be implicated in this sort of thing was a drug that was used for headaches and so on, and even after it seemed evident to people that this drug could cause trouble in some patients, but serious trouble, it took a number of years for some doctors to believe this, for it to be proven to their satisfaction.

I think we are now more ready to accept this, that some people in a population may have severe complications from a certain drug, while the rest of them go scot free, but it usually takes two to five years until this becomes apparent in ordinary use.

COMMISSIONER McCUTCHEON: You could say this about the sulphanamides?

DR. WIGHTMAN: Yes, or chlororaphin.

COMMISSIONER VAN WART: There is no organization in Canada that standardizes drugs?

DR. WIGHTMAN: No. Do you mean clinically testing or chemically standardizing?

COMMISSIONER VAN WART: Both clinically and chemically.

DR. WIGHTMAN: No, the Food and Drugs Division in the Department of National Health and Welfare has facilities to test samples, but it does not do it. It is a matter of routine.

COMMISSIONER VAN WART: No, but there is no body or organization which controls the standard of



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Farquharson 11658

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DR. FARQUHARSON: This is a question that has come up again and again, and it is a question that defies solution. Drugs are introduced at a tremendous rate. It is only when we speak, as Dr. Wightman did, of a compound given for a headache which has severe side effects only, say, in one person in 500 taking it. That drug was introduced in Germany and the German physicians just couldn't believe that it was doing the harm that was recognized in the United States and Canada, and they thought it was foolishness and a wrong conclusion drawn on the part of the doctors in this country. But one doctor may have seen hundreds of patients taking that drug without this serious illness, so the job of finding out about the dangers of drugs must be imposed on the whole medical profession and particularly those studying treatment by drugs in the universities.

I have been asked myself during my time as Professor of Medicine in Toronto to try to establish some body that would study all these things, but the study is beyond the comprehension of any one man or any one group of people.

There are far too many drugs for that to be done and I think it becomes part of the responsibility of every good medical organization, and particularly teaching organizations, to study as they go along in their daily work, and be prepared to see the inadequacies and the dangers of any treatment.

That is true of surgical treatment.

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We all see that as surgical operations become popular, some of them do good. The failures become more apparent over the years. More and better measures are devised.

It is true that in the ordinary directions we give to patients we learn more and more about the workings of the body, and how to help it. It is true of all drugs and there are such hosts of drugs that it takes a great deal of time and a great deal of careful, exacting scrutiny to recognize the dangers and to tell whether they are really as beneficial as they seem to be when they are first introduced.

As Dr. Wightman pointed out, the faith that a person has in a drug often makes a person, even with a serious disease, feel better for a time. When a person has no serious disease it also cures him if he has faith in his doctor.

COMMISSIONER VAN WART: We have heard all sorts of arguments about brand and generic name drugs, and the argument put forward in favour of the brand drugs is that some brands do a better job than other brands, and that is what makes me ask the question: is there any organization that standardizes drugs in Canada?

DR. FARQUHARSON: It has to pass the Food and Drugs Division and the producer that sells it has to give evidence that it is safe as far as he can tell and sometimes, as in the case of the drugs that harm the growing foetus, that can be found.

COMMISSIONER VAN WART: But I mean two



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Farquharson 11660

products sold under a generic name; they would have to be the same strength and the same chemical composition and everything, but when they are sold under brand names they are not, and I was just wondering if there was anybody in Canada that supervises or controls?

DR. FARQUHARSON: Except for the Department of Health, I think Dr. Wightman served in some of their committees in recent years, and I did in former years and he can state the present situation.

DR. WIGHTMAN: Well, as you know, there is a law that says if you are selling a drug that says there are 250 milligrams of drug X in this capsule, there must be 250 milligrams, plus or minus five and that the inspectors of the Food and Drugs Directorate are at liberty to go and pick up a handful of these capsules and analyze them, and if they are found to be deficient they may take steps about it. But they cannot do this to every batch that leaves the maker's factory and it is up to the -- they do test batches from various places. They test any batch anyone raises a question about, or complains about and I think they keep a special eye on certain manufacturers, whose inherent or whose own control mechanisms they suspect or know do not have control mechanisms.

In other words, if a drug company, a brand name means that a certain company makes this drug and backs it up, just as the Ford Motor Company backs up a Ford car, and that this company will protect its own good name by having chemists there testing their



11880 Farkuharson

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Wightman

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own output batch by batch, and seeing that it is up to scratch.

Another company may import batches and not take the same precautions. You prescribe a brand from a certain company because you feel confident that if they say that such-and-such a compound would be made the way you are accustomed to having it being made, and all the factors involved are likely to be taken care of. If you just name the drug by a generic term which says anybody's product could be given, you sacrifice that and take a chance that it will be as it should be, but you haven't any real assurance about it.

THE CHAIRMAN: So there is some real merit in the suggestion that has been made to us that great reliance can be put in certain brand names?

DR. FARQUHARSON: I think there is some merit in that. I think also, sir, that it is very important that the firms that have their brand name should have the official name of their drug prominently on their label so that every doctor knows what is in that drug by its official medical name, and sometimes the lack of this leads to trouble because there may be many different names on a given preparation and the doctor or the nurse, it is particularly difficult for the nurse when drugs are ordered by different brand names, that do not have on it a name so that she can say, this is phenobarbital, when it may be sold as luminol, or some other name.

THE CHAIRMAN: That is something that



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Farquharson

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DR. FARQUHARSON: The Food and Drug administration demands that the name be on the label.

THE CHAIRMAN: They could demand it be put on so that it is readable?

DR. FARQUHARSON: They made a rule at one time that it should have equal prominence, but that was interpreted by many companies that equal prominence was putting it at the top or the bottom of the label in extremely small type.

COMMISSIONER VAN WART: They could put a patent number on it.

THE CHAIRMAN: Is that sufficient?

COMMISSIONER VAN WART: Yes.

COMMISSIONER BALTZAN: You stress the importance of long-time experience in relation to drugs which is necessary in many cases to discover their adverse reactions, and that is an experience of something that sort of overflows. It is not a condemnation of not being able to observe, and I put it to you because of this reason.

Oxygen has been used for a long time and it is only in the last 10 or 12 years we have recognized two injurious effects of oxygen, so that no matter how long a drug is out, you still have to keep observation on the side effects.

DR. FARQUHARSON: I agree with that, Dr. Baltzan. In the generalization that, as we learn more about the body, we learn more of what drugs can do to it for good and for evil and that there are none





11542 Farquharson

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Farquharson

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of us that have a sufficiently comprehensive mind or sufficient understanding to predict what may happen and that it takes time and experience with the best and the most alert minds. It cannot be hurried.

COMMISSIONER BALTZAN: We just look for the best and forget sometimes to look for the worst?

DR. FARQUHARSON: That can happen. We may be hypnotized by the best and not see the worst.

COMMISSIONER BALTZAN: I put this question to you both, because it has come up repeatedly here when we are talking about drugs.

We have been told that the detailmen serve an educational purpose in their detailing of drugs to physicians, and then the question was put to the pharmacists, and they say that the detailmen - you know whom I am talking about?

DR. FARQUHARSON: Indeed, yes.

COMMISSIONER BALTZAN: Also serve an educational value to the pharmacist. Now, what is your general attitude towards that? May I couple it with one other thing in that same connection? This elaborate form of distribution of literature in connection with that - I don't want to use the word advertising, material?

DR. FARQUHARSON: Well, I think that some detailmen can be helpful and often are helpful. I think that they often give correct -- they usually give correct information about their own products.



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Wightman

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They even exaggerate the value of their own product and they even fail to give the very necessary information about the harmfulness of the product. They cannot be trusted for any comparison between their product and another product.

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I know that lots of doctors in busy practice, especially those who haven't the free communication of other doctors in their work, learn a great deal which is good and quite a bit that is bad from the detailman.

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DR. WIGHTMAN: I would say the same. I think the problem of the doctor is that he has to keep educating himself, he had to keep learning things. He can't close the door and operate what he has learned at medical school, and the detailman can teach him things, even if he tells untruths. In other words, the detailman can draw his attention to something which, if it sounds good enough, he can then turn to the literature, respectable sources, to examine it and he can maybe begin to take advantage of a new discovery he didn't take advantage of before.

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I think in general the education of the detailman is not very great, he doesn't teach the doctors much, but he can help them by drawing their attention to something that they can then study. About four years ago I was chairman of the pharmacy committee of the Canadian Association Journal, and we protested strongly about this mail. I don't think it is too useful largely because there is too much of it, it is not standard in its quality. There are some which come



THE CANADIAN ASSOCIATION OF PHARMACISTS

WIGHTMAN  
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Wightman

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4 to your desk which are very useful, others are merely  
5 an emotional appeal purely on an advertising plane and  
6 they are useless, and the bulk of it, which amounts to  
7 half a wastepaper can a week or more, is bad, I don't  
8 think it is helpful.

9 COMMISSIONER VAN WART: One other  
10 phase of practice. We have heard that there are certain  
11 plans or schemes, formularies, which are an essential  
12 part. What is your opinion of a drug formulary?

13 DR. WIGHTMAN: By a formulary you mean  
14 a list of drugs which can be used and he cannot use  
15 anything that is not on that list.

16 COMMISSIONER VAN WART: Yes, and  
17 probably some information about the drug.

18 DR. WIGHTMAN: Yes. The restrictive  
19 formulary is a poor thing. One thing we have tried to  
20 do in our hospital is to produce a list of drugs that  
21 drew attention to the price of it, as well as its proper  
22 name, and so, too, I think it is the responsibility of  
23 the doctors to know what kind of expenses they are  
24 incurring either on behalf of the patient or on behalf  
25 of the Hospital Services Commission, and this responsi-  
26 bility has been placed on their shoulders.

27 I should think there are drugs I could  
28 get along perfectly well without, but it might bother  
29 Dr. Farquharson because of the different kind of  
30 experience he has had. It is very difficult to come  
at from all the experience of doctors to have a drug  
that nobody cares about.

COMMISSIONER VAN WART: How often would





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COMMISSIONER VAN WART: Now often would



Wightman

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3 you revise this list?

4 DR. WIGHTMAN: We could revise it every  
5 month; we revise it every couple of years. It is  
6 getting a bigger and bigger job to revise it.

7 COMMISSIONER VAN WART: A formulary,  
8 a restrictive formulary of two years standing wouldn't  
9 be of any interest to medicine.

10 DR. WIGHTMAN: I wouldn't think so,  
11 because some new drug might come along that might have  
12 some very useful attributes.

13 COMMISSIONER VAN WART: Or some toxic  
14 drug that was in it?

15 DR. WIGHTMAN: Every year there are  
16 about 200 new drugs and about 400 new medicines come on  
17 the market which are a mixture of the old ones. So there  
18 is a great turnover in the field.

19 COMMISSIONER STRACHAN: Mr. Chairman,  
20 I think my question may have been answered by inference,  
21 and that refers to a statement made by a certain  
22 pharmaceutical group the other day to the effect that  
23 drug A and drug B may have the same constituents or  
24 elements in them, but the efficacy of those drugs might  
25 be different because of the method by which they were  
26 compounded. Is that true?

27 DR. WIGHTMAN: Yes. There was an  
28 example of this. One of the reputable drug houses  
29 decided to change one of its tablets of a certain medicine  
30 in order to make it larger because there was confusion  
between it and other pills that they had, so they then  
added incipient material to make it bigger, and this  
interfered with its effectiveness and it suddenly all went

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Wightman

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4 out of control, and that was a sharp reminder that the  
5 parts which are not necessarily the active ingredient  
6 may have quite an influence on the part that is active.

7 COMMISSIONER STRACHAN: Has government  
8 body any control over compounding those drugs or have  
9 they any method which they test the compounding of drugs?

10 DR. WIGHTMAN: The company must notify  
11 the government if they make any change. Nobody in the  
12 government or the company had any idea that this would  
13 occur, this change in effectiveness would occur, and  
14 it didn't occur to anybody that it would be necessary to  
15 test it, and the only way it would have been tested  
16 was on human beings. The test was not carried out  
17 because neither the company nor the pharmacist thought  
18 it was needed. So there would have been a mechanism  
19 if people had anticipated this was possible. I am sure  
20 if this company said they wanted to change the pill again  
21 they would know they would have to push it right down in  
22 the clinical test to make sure there wouldn't be any  
23 difference. The hardness of the coat, the inertness of  
24 the material may affect its effectiveness. Some of them  
25 are controlled by definition. There are regulations  
26 which say what are the limits. The inert binder which  
27 is used is limited to a certain list of things, but the  
28 relationship of the drug to the incipient, to the coat  
29 and all these things have to be tested clinically in  
30 order to find what the net effect is going to be.

COMMISSIONER BALTZAN: The pharmaceutical  
manufacturers have contributed greatly toward research  
in pharmaceuticals and the production of acceptable and



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COMMISSIONER BARTMAN: The pharmaceutical

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Wightman

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enduring drugs.

DR. FARQUHARSON: The good manufacturers have spent millions and millions of dollars in research, which has been actually wonderful. Without them we wouldn't have had sulfonamides, which had tremendous effect before we had penicillin. Without them Fleming's observation and Fleury's work in Oxford on penicillin wouldn't have made penicillin available for years and years and wouldn't have made it nearly as cheap as it is now. Without them we wouldn't have had one antibiotic of great usefulness whatsoever, and without them we wouldn't have had the host of new drugs which affect the function of one particular part of the body and be very useful in clinical medicine. And without them we wouldn't have had the multitude of new diseases in using new drugs indiscriminately when they can do great harm.

THE CHAIRMAN: Thank you very much. It is very kind of you to accept our invitation for this discussion and presentation.

DR. WIGHTMAN: It has been a pleasure. Thank you.





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vignette

DR. FARQUHARSON: The good manufacturers  
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THE SECRETARY: Mr. Chairman, the next brief is that of the Canadian Plumbing and Mechanical Contractors' Association and it will be known as Exhibit number 332.

---EXHIBIT NO. 332: Submission of the Canadian Plumbing and Mechanical Contractors' Association.

SUBMISSION OF  
THE CANADIAN PLUMBING AND MECHANICAL CONTRACTORS' ASSOCIATION

APPEARANCES:

MR. ROY E. BELYEA  
MR. R. DAVIDSON

THE CHAIRMAN: Yes, Mr. Belyea?

MR. BELYEA: This brief is respectfully submitted on behalf of the member companies of the Canadian Plumbing and Mechanical Contractors Association who sell and install approximately 90% of all the plumbing, heating, air conditioning and ventilating materials installed in Canada and whose approximately 1,200 member firms from coast to coast employ over 95% of all organized labour in this Trade in the Dominion.

Among the objectives of this Association, created by Federal Charter in 1942 is the responsibility to make representation with respect to Federal, Provincial and Municipal legislation for the improvement of Plumbing and Mechanical Trades and Safety and Health legislation.



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S U B M I S S I O N O F

THE CANADIAN PLUMBING AND MECHANICAL CONTRACTORS' ASSOCIATION

MR. R. DAVIDSON

THE CHAIRMAN: Yes, Mr. Davidson.

MR. BEVILA: This brief is now being

fully submitted on behalf of the member companies of the Canadian Plumbing and Mechanical Contractors' Association who sell and install approximately 90% of all the plumbing, heating, air conditioning and ventilating materials installed in Canada and whose approximately 1,200 member firms from coast to coast employ over 350,000 men and women in this Trade in the Dominion.

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Belyea 11670

Preamble - It is noted that among the terms of reference of the Royal Commission on Health Services, it is charged with enquiry into existing facilities and methods of providing personal health services and methods of improving such existing health services. It is also noted that in his statement at the opening of the preliminary hearing of the Commission on September 27th, 1961, Mr. Justice Hall observed that "inadequate health care means a lower standard of living".

Among those trades and professions which are directly or indirectly concerned with ensuring or safeguarding public health, it is suggested that the plumbing trade, whose daily endeavours concern the provision of pure potable water into the homes, schools, factories and private and public buildings of this land and the removal of impure water and industrial wastes into proper disposal units, should be qualified to report on the health situation as it sees it.

This Association and its predecessor, the National Association of Master Plumbers, Steam, Gas and Pipe Fitters of Canada founded in 1895 was responsible to a large degree for the establishment of the various provincial Plumbing Codes that exist in Canada today and it is recognized that this field of Health Services falls wholly within provincial jurisdiction.

Provincial Plumbing Codes, designed to ensure minimum standards of plumbing installations are on the statutes of the provinces of Alberta, Saskatchewan, Manitoba, Ontario, Quebec and New Brunswick. Prince Edward Island has completed arrangements for such a code



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Belyea 11671

and it is expected to be in operation this year. British Columbia, Nova Scotia and Newfoundland have no provincial Plumbing Codes. The Plumbing Codes that are on the statutes of the various provinces abovenoted are effective only insofar as they are enforced and their enforcement is frequently very limited because of the shortage of funds to make inspection and enforcement possible.

There are many authorities which bind good health with good sanitation. For 444 years London's powerful Royal College of Physicians has been keeping watch over the health of England. It led the struggle against bubonic plague in the 17th century by condemning primitive sanitation conditions. It was recognized that the epidemic that occurred during the Chicago World's Fair some years ago was due to impurities in the water system at the Fair.

Dr. Wademan, former head of the World Health Association is reported to have stated "if I had soap and water I could wipe out diseases across the world. What I want most is clear, pure water" and his organization, in reporting health conditions in India and other Asian countries has indicated that the prevalence of cholera, dysentary and infant diseases is due largely to bad sanitary conditions. In this country this Trade has noted many cases where the water supplies serving Canadian communities are in dangerous condition. In Kensington, Prince Edward Island, in 1950 a survey carried out by the Department of Health predicted that the water would have a 90% nitrate content in 10 years. It went up to 97% in 3 years - and one of the main causes was due to the erection





Belgian 1161

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Belyea 11672

of cesspools at a depth of 6 to 8 feet when the water table was 12 feet deep with a result that impurities filtered down into the town water supply. The nitrate content developed as a result of this action was powerful enough to kill young infants.

In Charlottetown the sanitary inspector discovered that laundry water was being introduced into a school water supply some three blocks away. These facts may be confirmed by the sanitary engineer in the Department of Health at Charlottetown. In the Metropolitan District of Greater Winnipeg today, raw effluent and sewage is discharged into the slow moving Red and Assinaboine Rivers which flows through the metropolitan area and through and into other urban areas further downstream.

The Kamloops, B.C. newspaper on November 2, 1960, carried the headline "Village Sanitation Rapped as a Mess" when it was disclosed that, at the request of a number of alarmed citizens an examination uncovered an "appalling" number of open out-houses as well as improperly installed and overflowing septic tanks within the municipality - some within 50 feet of the leading cafe in the community and another less than 150 feet from another restaurant. Another examination was made in November 1961 and indicated a deterioration over conditions discovered in an examination made in the same municipality in July 1961. Dr. D.M. Black, Medical Health Director in Kamloops can confirm the details of this examination and of the warnings given.

Warnings of dangers to the health of residents of British Columbia in the form of contaminated water which could spread typhoid, hepatitis and other



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enteric diseases were also carried in the "Daily Colonist" of Victoria, B.C. on March 9th, 1962 and on March 9th, 1962 the Vancouver Sun quoted Mr. W.W. O'Keeffe, Secretary Manager of the British Columbia Branch of this Association who warned that, whilst the City of Vancouver was spending nearly 17 million dollars on the Iona Sewage Disposal Plant to keep the beaches and the Southern Harbour clean, the cities of North Vancouver and other adjoining areas were allowed to pollute the Fraser River and inner harbour of Vancouver with raw sewage, making the inner harbour of Vancouver the "largest salt water cess-pool in Canada."

During 1960, there were 898 cases of hepatitis reported in British Columbia. Since August 1961 this number has increased, particularly in areas where no Codes, rigid inspection of sewage, septic tanks, water supplies and other factors closely associated with good sanitation, exist.

In Nova Scotia there is an active and expensive program to induce tourists to visit the province. It is suggested, however, that the lack of safe sanitary codes and regulations coupled with the dangers that can result from present unsafe conditions of water supply, could easily wreck all tourist attractions. The story of dangerous water and unsafe sanitary conditions can readily be learned from the plumbing trade in that province and is reflected in Appendix "A" to this Brief.

This Trade has observed, with some concern the growing population of "house boats" in the smaller inland lake resort areas such as Lake Muskoka,



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enteric diseases were also carried in the "Daily Colonist" of Victoria, B.C. on March 9th, 1962 and on March 9th, 1962 the Vancouver Sun quoted Mr. W.W. O'Keefe, Secretary Manager of the British Columbia Branch of this Association who warned that, whilst the City of Vancouver was spending nearly 15 million dollars on the Iona sewage disposal plant to keep the beaches and the southern harbour clean, the cities of North Vancouver and other adjoining areas were allowed to pollute the Fraser River and inner harbour of Vancouver with raw sewage, making the inner harbour of Vancouver the "largest salt water cess-pool in Canada."

During 1960, there were 643 cases of hepatitis reported in British Columbia. Since August 1961 this number has increased, particularly in areas where no codes, rigid inspection of sewage, septic tanks, water supplies and other factors closely associated with food sanitation, exist.

In Nova Scotia there is an active and expensive program to induce tourists to visit the province. It is suggested, however, that the lack of safe sanitary codes and regulations coupled with the dangers that can result from present unsafe conditions of water supply, could easily wreck all tourist attractions. The story of dangerous water and unsafe sanitary conditions can readily be learned from the plumbing trade in that province and is reflected in Appendix "A" to this brief. This Trade has observed, with some concern the growing population of "house boats" in the smaller inland lake resort areas such as Lake Umbagog



Belyea 11674

Rosseau, Joseph, Lake of Bays etc. These "house boats" are used as summer residences that have the advantage of mobility and are protected by marine regulations effecting vessels on the high seas. Nevertheless they do also discharge raw sewage into lakes which supply the cottage residents with drinking water, and the increase in numbers of these craft only expedites the possibility of disease from polluted waters.

The Dominion Bureau of Statistics figures indicate clearly that the incidence of hepatitis and other enteric diseases is appreciably lower in provinces which have good Plumbing Codes with effective legislation and rigid inspection. Statistics, graphs, records, etc. from the Dominion Bureau of Statistics are appended to this Brief for study and examination.

However these tell only a part of the story. The big story associated with faulty plumbing installations coupled with indiscriminate pollution disposal, is hidden in the statistics which show an alarming increase in infectious enteric diseases chiefly in areas where there are little or no plumbing or sanitary codes.

Some press, civic leaders and health departments appear to have sought every subterfuge to "sweep this problem under the rug". Increased population density, coupled with ill planned (if planned at all) urban and rural sprawl has reached grotesque proportions. Little, if any provision has been made for competent, well-designed plumbing or sewage disposal units and it is suggested that many who decry adverse publicity today may



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Some press, civic leaders and health departments appear to have sought every subterfuge to "sweep this problem under the rug". Increased population density, coupled with ill planned (or planned at all) urban and rural growth has resulted in increased pollution. Little, if any provision has been made for competent, well-designed plumbing or sewage disposal units and it is suggested that many who carry adverse publicity today may



Belyea 11675

will find themselves (in some areas) in the midst of a booming epidemic tomorrow.

Efforts have been made by this Association to introduce minimum plumbing regulations into British Columbia, Nova Scotia and Newfoundland. It is recognized that financial problems do occur, especially in smaller urban areas. However, little success has been achieved to this date.

In April 1962 Nova Scotia passed Bill #112 to amend Chapter 234 of the Revised Statutes, 1954, The Public Health Act and Acts in Amendment thereof. In its provisions it empowered the Minister of Health to "provide for safe and potable water supplies, for the control of sources of water and systems of distribution and for the purpose of preventing contamination or pollution of water that is used for human consumption" and "respecting the plumbing and drainage of buildings, etc.", but it did not specify mandatory regulations covering these matters. Thus, whilst Bill #112 provided "permissive" regulations to prevent pollution of water, it took no further steps to ensure that the citizenry of that province would be protected from diseases resulting from water pollution.

Conclusion - As a result of observations by members of this Association of dangerous drinking water conditions resulting from faulty plumbing installation, of cases of cross connections causing pollution of water systems, and of the sorry lack of inspection and absence of regulations prohibiting unskilled personnel from tapping into public water systems, this Association strongly recommends the



11075 Belyaev

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"provide for safe and potable water supplies, in the

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"permissive" regulations to prevent pollution of water.

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of that province would be protected from disease resulting

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of this Association of dangerous drinking water conditions

resulting from faulty plumbing installation, or cases of

cross connections causing pollution of water systems, and

of the sorry lack of inspection and absence of regulations

prohibiting unskilled personnel from carrying out public

water systems, this Association strongly recommends the





Belyea 11676

1  
2  
3  
4 adoption by all provinces of safe minimum plumbing  
5 regulations based on the National Plumbing Code, part of  
6 the National Building Code of Canada. It further  
7 recommends that these Plumbing Codes, designed to safe-  
8 guard the health and safety of the citizens of this  
9 country, should be mandatory in every province and in every  
10 municipality where there is a public water system.

11 It is not possible to estimate the  
12 cost of inspection because these costs will vary accord-  
13 ing to the size of the municipality but codes are not too  
14 effective unless inspection is carried out.

15 It is further recommended that, in all  
16 cases where new plumbing is being installed and new  
17 entries are being made into public water systems, that plans  
18 of the work to be done should be required by the building  
19 or health offices of the municipality concerned, permits  
20 granted to qualified licensed applicants, and inspection  
21 carried out by the municipal or provincial plumbing  
22 inspectors.

23 It recommends that these regulations should  
24 become part of each Provincial Health Act and should be  
25 rigidly enforced.

26 Recovery of at least a portion of the  
27 cost of permits and inspection can be made by permit and  
28 inspection fees and samples of these are included in  
29 Appendix B to this Brief.

30 It also suggests that all houseboats or  
marine craft that have living accommodation should be  
licensed and required to install septic tanks which will  
prevent pollution of our inland waters.

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 marine craft that are living accommodation should be  
 licensed and required to hold a licence which will  
 prevent pollution of our inland waters.



Belyea 11677

To conclude it is noted that there are regulations in many provinces to control the qualifications of personnel who work in the automotive trade. Hydro-electric installations are carefully regulated. But in the important area of water for human consumption and sewage disposal there appears to be an apathy or refusal to accept the dangers of epidemic and disease.

To ensure public safety this should be corrected.

THE CHAIRMAN: Thank you very much, Mr. Belyea. If I may be permitted to observe that in this brief you have confined yourself to those areas in which you are fully knowledgeable. Your recommendation is in line with the things you know from your own experience.

Having read your brief in full as you did we have the whole picture as you wish to present it. You recognize that much of what you suggest here is wholly in the Provincial field, but there are areas covered in your brief that are within the Federal field as well, such as pollution of inland navigable waters and that kind of thing. I was wondering, having read the brief, do you wish to make any further comments in connection with it?

MR. BELYEA: I do not believe there is very much I can say. I might add that we have only touched, just skirted around the edge of this thing so far as the number of conditions that are shocking. If people only realized the dangers that they are in in many





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TORONTO, ONTARIO

# ROYAL COMMISSION ON HEALTH SERVICES

Belyea 11678

cases because of improperly installed plumbing, for instance, the dysentery that broke out in Chicago, maybe you will recall, was caused by cross-connections and they were taking water out of bath tubs down into the drinking water. These are things that need somebody's attention and, we are humble people, but we nevertheless are proud of the part we play in helping to preserve the health of the people of this country.

THE CHAIRMAN: I do not think you have apology to make for being here with this brief. This is an important subject and certainly if you had not come here this kind of thing might well have escaped our attention. We are very much obliged to you for having brought such an important matter to our attention and for documenting it as you have done here today. Thank you.

We will rise now until 9:30 tomorrow morning.

-----Adjournment.



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We will miss you until 2:30 tomorrow

morning.

-----Adjutant.



# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

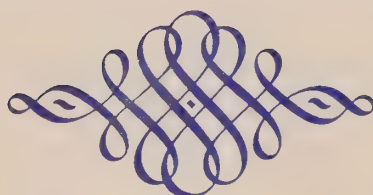
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THE CANADIAN SOCIETY FOR CLINICAL





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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 29th of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O.J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE

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DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:





---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning is from the Board of Trade of Metropolitan Toronto which will be exhibit 333. Mr. McLean will introduce his group.

---EXHIBIT NO. 333:

Submission of the Board of Trade of Metropolitan Toronto.

SUBMISSION OF  
BOARD OF TRADE OF METROPOLITAN TORONTO

APPEARANCES:

W. E. McLean, Esq. Q.C.  
A. C. Crysler, Esq. Q.C.  
T. G. O'Connor, Esq.

MR. McLEAN: Mr. Chairman, I am Wilson McLean. I have been Chairman of the Committee which, to an extent, is responsible for the preparation of this brief. Also, I am speaking as a member of the Council of the Board of Trade of Metropolitan Toronto.

I would have undertaken the reading of this brief but I am suffering from a laryngeal cold. Mr. Crysler, legal officer of the Board of Trade has kindly undertaken to read the brief, if that is the wish of the Commission. I think perhaps it might be the most expeditious manner of disposing of it. It is quite short.

THE CHAIRMAN: Thank you. Mr. Crysler, you may just remain in your chair if you don't mind.

MR. CRYSLER: Thank you. Mr. Chairman



THE SECRETARY: Mr. Chairman, the

first submission this morning is from the Board of  
Trade of Metropolitan Toronto which will be exhibit 333.

Submission of the Board  
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---EXHIBIT NO. 333:

SUBMISSION OF

BOARD OF TRADE OF METROPOLITAN TORONTO

V. E. McLean, Esq., J.C.  
A. C. Criveller, Esq., J.C.  
T. C. O'Connor, Esq.

APPEARANCES:

MR. McLEAN: Mr. Chairman, I am pleased  
to have been Chairman of the Committee which, to  
an extent, is responsible for the preparation of this  
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THE CHAIRMAN: Thank you. Mr. Criveller,

you may just remain in your chair if you don't mind.

MR. CRIVELLER: Thank you. Mr. Chairman



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4 this brief is not very long. We hope that after having  
5 heard so many briefs it won't overly weary you.

6 We start out by saying that the Board  
7 of Trade of Metropolitan Toronto welcomes this opportunity  
8 to submit its views to you concerning Health Services  
9 to the Royal Commission on Health Services.

10 We then tell you just a little bit  
11 about the nature of our membership, on behalf of whom  
12 we speak. Our membership consists of more than 9,500  
13 persons. Actually, it is a little more than 9,700  
14 representing large and small business firms engaged in  
15 all phases of business activity and the professions.  
16 While this membership is concentrated mainly in the  
17 Toronto area, the larger member firms conduct businesses  
18 which in numerous cases are provincial or national in  
19 scope, or extend into the area of international trade.  
20 In view of the nature of its membership, the Board  
21 believes that it can claim fairly to represent the views  
22 of a major cross section of the business and professional  
23 interests of the Province.

24 THE CHAIRMAN: Would you care to  
25 translate that into figures?

26 MR. CRYSLER: I have not, I regret  
27 sir, a definite breakdown but I would say that the great  
28 majority, the biggest classification of our membership  
29 would be manufacturers. The next biggest classification  
30 would be financial. By that I include banks, insurance  
companies, trust companies, stock brokerage firms, the  
whole financial community.

The third would be the distribution



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Crysler

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4 trades, retail and wholesale. Of course, nowadays mostly  
5 retail.

6 Now I regret that I cannot give you the  
7 figures but if you would be interested, sir, I would  
8 be very glad to have them looked up and write a letter.

9 THE CHAIRMAN: I think we would like  
10 to have it.

11 MR. CRYSLER: Very good sir. We will  
12 supply you with the figures on our classifications but  
13 I have mentioned the principal classifications.

14 The Board is conscious that the people  
15 of a country are its most valuable continuing asset for  
16 it is on them that the operation of all facets of the  
17 life of a country depends. The Board is equally conscious  
18 that good health is one of the principal factors which  
19 contributes to enabling a people to achieve its full  
20 potential growth. Even more important is the creative  
21 development which establishes a nation among the leaders  
22 whose development confers lasting benefits not only on  
23 its own people, but on many others. Nowhere is this  
24 aspect more important than in Health Services.

25 In view of the considerations already  
26 mentioned, the Board has followed with great interest  
27 the proceedings of the Royal Commission and the principal  
28 proposals submitted to it. In particular, we have had  
29 an opportunity to study the submissions already made to  
30 you by the Canadian Chamber of Commerce, the Ontario  
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The principal aspects of the Health Services question have already been presented to you in some detail. Accordingly, it is not our intention to deal with these matters in detail again. We shall refer briefly to those aspects we consider of special importance and embark on discussion of some features of them which in our view can be developed further in discussion than, insofar as we are aware, has occurred up to this time.

Medical Manpower: At the present time there are not enough physicians graduating in Canada to keep pace with our expanding population. Even with an annual immigration of doctors of more than three hundred during the last 10 years (about two-thirds of whom came from the United Kingdom) the doctor-patient ratio has barely been maintained during this period. The total annual increase in physicians from both home and abroad is not adequate for new staff and new areas of health. It has been estimated that even on the basis of the present annual Canadian graduation and immigration of physicians from abroad, there will be a deficiency of about one thousand physicians in Canada by 1970.

As slightly more than two hundred doctors come to us each year from the United Kingdom, and as it is anticipated there will be a crisis in the supply of doctors in that country by about 1965, it is to be anticipated that measures will have to be taken there to make the conditions of professional practice more attractive. To the degree that any such measures succeed in their object, one of our principal sources of



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supply of physicians from abroad will be diminished and our overall deficiency of physicians will be correspondingly increased.

In addition to this anticipated shortage in the case of physicians, shortages are now clearly apparent in the cases of dentists and nurses.

Educational Facilities: From the material placed before the Royal Commission it appears that existing professional educational facilities in Canada cannot materially increase the output of physicians. Obviously, therefore, universities should be encouraged to develop their facilities for training medical manpower and where appropriate the establishment of new educational institutions should also be encouraged. It is to be kept in mind that there is a time gap of upwards of ten years between the decision to build a new school and the graduation of its first class.

Students: When more educational facilities are available, the question of additional students for training as physicians and dentists will arise. Many motives and reasons will play their part in inducing young people to enter these professions. Where financial need is a factor, more and larger scholarships, loans and bursaries should be made available for those students who establish their suitability. It should not be assumed, however, that financial assistance alone will bring forward the required numbers of students, especially the required number of the right type of students, for the medical profession. It will be necessary that the profession





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5 creative, individualistic and material inducements  
6 that will attract to the profession young people who  
7 possess the qualities that will gain, and, by the high  
8 standard of their work, hold the confidence of patients.

9 Institutional Facilities: There is  
10 at present a shortage of institutional facilities in  
11 many parts of Canada. In particular, there is a  
12 special and general shortage of rehabilitation facilities  
13 and other facilities for care of the aged, chronically  
14 ill and the mentally ill. The more successful the  
15 treatment of acute disease, the greater will be the  
16 ultimate incidence of degenerative disease and the number  
17 of the aged who require institutional care. It is to  
18 be anticipated, therefore, that there will be an  
19 increasing demand for institutional facilities. It will  
20 not be practical, however, to bring into existence  
21 substantially increased institutional facilities until  
22 there is available the additional trained professional  
23 manpower necessary to operate them.

24 The Problem: The problem may be  
25 stated in its most simplified form in terms of these  
26 basic needs - (1) the training of more professional  
27 medical manpower, (2) the provision of more educational  
28 facilities and (3) the provision of more institutional  
29 facilities. Since the operation of additional  
30 institutional facilities is dependent upon additional  
professionally trained medical manpower, which in turn,  
is dependent on additional educational facilities, it  
seems clear that the first priority is the provision of

be operated on a basis that will provide the blend of creative, individualistic and material inducements that will attract to the profession young people who possess the qualities that will gain, and, by the high standard of their work, hold the confidence of patients.

#### Institutional Facilities: There is

at present a shortage of institutional facilities in many parts of Canada. In particular, there is a special and general shortage of rehabilitation facilities and other facilities for care of the aged, chronically ill and the mentally ill. The more successful the treatment of acute disease, the greater will be the ultimate incidence of degenerative disease and the number of the aged who require institutional care. It is to be anticipated, therefore, that there will be an increasing demand for institutional facilities. It will not be practical, however, to bring into existence substantially increased institutional facilities until there is available the additional trained professional manpower necessary to operate them.

#### The Problem: The problem may be

stated in its most simplified form in terms of these basic needs - (1) the training of more professional medical manpower, (2) the provision of more educational facilities and (3) the provision of more institutional facilities. Since the operation of additional institutional facilities is dependent upon additional professionally trained medical manpower, which in turn, is dependent on additional educational facilities, it seems clear that the first priority is the provision of





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4 additional professional manpower and additional institu-  
5 tional facilities should be appropriately related to  
6 each other.

7 Financing: Once the Health Services  
8 problem and its priorities have been formulated, it  
9 becomes necessary to consider the ways and means of  
10 providing the funds necessary to bring these services  
11 into being. The appropriate starting point for consi-  
12 dering the financial aspects of our Health Services  
13 problem is to start with the stage at which we now are.

14 Hospitalization: Almost all citizens  
15 in all Provinces in Canada are covered for basic ward-  
16 hospital care, plus in-Hospital diagnostic services, which  
17 are substantially financed out of tax monies and  
18 administered by Provincial Governments.

19 The institution of government hospital  
20 care programmes has led to suggestions that medical  
21 services be provided similarly by programmes substantially  
22 financed out of tax monies and administered by a  
23 Government or by Governments.

24 Distinctions Between Hospital Care and  
25 Medical Services: There are, however, certain important  
26 differences between hospital care and medical services.  
27 Briefly, hospital care is a somewhat impersonal  
28 institutional service whereas few relationships are more  
29 personal than that between physician and patient. In  
30 addition, hospital care is initiated and controlled by  
the doctor, whereas medical services are initiated by  
the patient. Accordingly, when government assumes  
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4 of a doctor concerning the need for hospital care. Even  
5 with this protection the cost of hospital care has risen  
6 to more than three times the amount originally estimated.  
7 However, when government assumes liability for medical  
8 services, the doctor loses much of his capacity to  
9 protect the liability of government by the exercise  
10 of professional judgment for he can scarcely avoid pro-  
11 viding medical service to those who ask for it.

12 THE CHAIRMAN: Would you mind expanding  
13 on that? Why do the doctors act differently in the  
14 two situations?

15 MR. CRYSLER: I think it would be for  
16 this reason: The doctor always must provide professional  
17 service whether it be that the citizen has a right, or  
18 conceives himself to have a right under a State service  
19 or whether it is merely the oath of the profession.

20 Now having done that, it is then  
21 within the doctor's judgment to say whether his services  
22 can be adequately provided within the home or whether  
23 the patient should go to the hospital and I think it  
24 is easier for the doctor to make that decision than  
25 somebody appears at his office, starts in the train  
26 of medical consultation, and so forth.

27 THE CHAIRMAN: Just at that stage --  
28 you say it is easier for him not to send the patient  
29 to the hospital.

30 MR. CRYSLER: Than refuse treatment  
in the first place.

THE CHAIRMAN: But at this stage  
there is not impediment to the patient going to the





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THE CHAIRMAN: Just at that stage -- you say it is easier for him not to send the patient to the hospital.

MR. CRYSLER: Then refuse treatment in the first place.

THE CHAIRMAN: But at this stage there is no impediment to the patient going to the



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hospital because there has been prepayment for the hospital service.

MR. CRYSLER: Oh there has been prepayment. I agree sir but still, normally, I think the patient goes to the hospital on the physician's advice rather than his own initiative.

THE CHAIRMAN: In either event?

MR. CRYSLER: In either event sir, yes. Perhaps I can clear up a point. We do not anticipate that the hospital aspect would change if there was State medicine. What we are seeking to say here is that the Government is incurring in medical services a liability which is controlled almost wholly by the patient.



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THE CHAIRMAN: Why by the patient in the case of medical service and by the doctor in the case of the hospital, when there is prepayment in both cases?

MR. CRYSLER: Again, the patient walks in and, let us say, they think that they need some sort of investigation, treatment, diagnosis or something else. At that time the doctor may be able to exercise his judgment. He may have a pretty shrewd idea of what that patient really needs, but he cannot quite say no, because even the medical service is prepaid to the state as of right and I am reliably informed that quite often people in that connection concede that these things are as of right and they demand it.

I think perhaps we are trying to narrow it down to this. Maybe this helps. At the stage of medical service and all that that might set in train, the doctor really does not know, and he would be in rather bad case if he refused.

THE CHAIRMAN: Even to make an initial examination?

MR. CRYSLER: He has got to go that far.

THE CHAIRMAN: And with the hospital he makes the examination before he makes the decision?

MR. CRYSLER: That is it. I would be the first to admit that perhaps there is not an absolutely clear and hard and fast distinction between the two cases.

THE CHAIRMAN: I see your point, Mr.

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THE CHAIRMAN: I see your point, Mr.



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MR. CRYSLER: But we do believe there is a point worth mentioning.

THE CHAIRMAN: Thank you very much.

MR. CRYSLER: Insurance and Prepayment Plans: During the past two decades there has been a large and continuing development of insurance and prepayment plans. Insurance is provided by insurers and provides for the payment of stated amounts when specified medical costs occur. It usually involves the insured paying some part of the doctor's bill as a form of co-insurance. Prepayment plans are sponsored by the medical profession across Canada and are a form of budgeting because the complete cost of all, or almost all, physicians' services are paid. Coverage includes, under these two methods, medical, surgical, hospital, prescription drug, loss of income and major and comprehensive medical expense insurance. More than nine million Canadians now have protection under such schemes and the dynamics for further substantial expansion of such schemes do not appear to have weakened.

Limitations: There have been limitations in connection with the insurance and prepayment plans. The plans have not been available to those who could not pay the cost of them. Also, there have been difficulties for the self-employed, those employed in small establishments, the older age group, individuals with chronic illnesses who are not associated with an employee group and psychiatric cases.

Extension of Voluntary Health Insurance



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Coverage: In the light of these considerations, the plan for extension of voluntary health insurance coverage described in the submission of the Canadian Health Insurance Association is of great interest. According to the description of the plan it will extend health insurance coverage for medical treatment to all Canadians, regardless of health, age, occupation or place of residence. Premiums will be subject to a maximum limit but otherwise determined on a competitive basis. The proposed plan would provide reasonably comprehensive coverage of medical expenses both in and out of hospital.

At the least, this plan for extension of voluntary health insurance will enable and result in many more Canadians acquiring insurance protection against the financial hazards of ill health. It may well contain the basis for an expansion of health insurance that will go far to meeting the needs of Canadians, apart from those who are wholly or partly medically indigent, for this protection. The Board commends this plan to the Royal Commission for careful study of its potential usefulness.

THE CHAIRMAN: We did have an opportunity to discuss this with the insurance representatives and to discuss some of the limitations and exclusions which were proposed, and it may well be that the industry even may take another look in regard to exclusions, in terms of psychiatric care, and that kind of thing.

MR. CRYSLER: Well, we don't pass



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judgment on the plan, but we do think it is a line that will well bear looking into, and it may be helpful.

Socialized Medicine: Probably the most contentious suggestion which has been, or may be, submitted to the Royal Commission is for socialized medicine under which the state assumes responsibility for both the cost of medical service and the ultimate responsibility for the services themselves. To some people it seems to be an answer to the Health Services problem and to cover the persons not covered by voluntary insurance, principally those who are unable to pay the cost of insurance. The problem, however, is not so easily solved for a number of reasons, not the least of which is the acid test of experience under a system of socialized medicine where such a system has been in operation in the United Kingdom.

The Medical Profession: While Governments undoubtedly have the legal power to socialize medical services and in effect make doctors civil servants, it is clearly beyond the power of Government to make the medical profession function well in any system which is inimical to the good functioning of the profession. The responsible leaders of the profession, supported by the great majority of medical practitioners, say that socialized medical services is inimical to the good functioning of the profession. Presumably the majority of doctors themselves know best how their profession should be operated.

Moreover, it is difficult to visualize how a solution contrary to their views could be



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15 something like a crisis in the supply of doctors may  
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23 for his services exists, than for a doctor to leave the  
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27 A learned profession necessarily  
28 includes a significant number of highly creative and  
29 highly individualized leaders who set the tone and morale  
30 of the profession. Such people are least of all suscep-  
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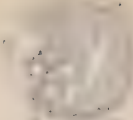
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judgment of the members of the profession.

Defects of Socialized Medicine: The opposition of the medical profession to socialized medicine is not founded in caprice. Solid grounds are given by the spokesmen of the profession as the basis for their attitude.

Dynamics and Flexibility: Like most other professions, the medical profession is highly dynamic, not static, in its character. No group of people so trained to think intensively could be otherwise. Society is the beneficiary of the resulting creativity. But the process cannot go on nor can the harvest of creativity be garnered save within a flexible framework. Such a framework is precisely what a great administrative department of government is least able to provide for such departments tend towards a static character. It is in a multiplicity of small autonomous operating units that the necessary flexible framework is to be found.

The doctors point to the inability of the Bismarckean system of socialized medicine in Germany to bridge the gap between a service which was primarily preventive and general, but was to become curative and individual in character. Now it appears that the practice of medicine is about to enter upon a new phase of treatment based on the patient's total environment. Psychiatric and related services are on the increase. And progressive success in the curing of acute disease must be reflected in a subsequent increase in degenerative disease and in the care of the aged.



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Any state medical service established now is more than likely to have an experience in a different context comparable to that of the system established by Bismarck and to be a bar to creative development. The need is rather for a flexible professional framework which is conducive to creative growth.

Budgetary Considerations: There is a tendency to make a superficial assumption that if the state assumes responsibility for the cost of medical services, those services are automatically assured of all financial support needed for their fullest possible development. Such an assumption does not take into account the fact that the appropriation of public funds in a governmental budget is a political decision. In making up its annual budget a government must reconcile the conflicting claims of its several spending departments with the amount of revenue it is expedient to raise.

Budgetary limitation on the provision of funds is evident most frequently in relation to capital expenditures. However, it is always to be kept in mind that a limitation on funds for capital expenditure on the creation of additional institutional facilities can be used as an indirect curb on otherwise uncontrollable operating costs. In either case the cause of medical services is not served to the best advantage and it is a situation which is almost bound to occur in times of economic recession.

Socialized Medicine Is Not The Solution:  
Socialized medicine is not the solution to our Health

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#### Necessary Considerations: There is

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#### Specialized Medicine Is Not The Solution:

Specialized medicine is not the solution to our health



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Services. Its basic defect is that it does not contain within itself the creative influences which lead to improved medical services. At best, it only provides a temporary financial palliative on the basis of the status quo.

There is, however, a wide field for Governments to extend financial aid in the field of medical services in ways that would support and encourage the creative development of these services and extend aid to those who need it in order to obtain benefits at the accepted standards for such services.

#### The Role of Government

Financial Aid: While it is inadvisable for governments to assume responsibility for the cost of medical services, there are wide and fruitful areas for government financial aid. Assistance by way of capital expenditures in the provision and equipping of physical facilities for professional teaching and care have been a traditional area of government action. Governments may also contribute greatly to the advancement of medical services by extending financial support to research. Likewise, governments should channel financial aid towards aiding people in low income groups or any others who for valid reasons are financially unable to provide themselves with protection against their medical care expenses.



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Now, sir, the rest is merely a summary in brief form of what we have already gone over.

THE CHAIRMAN: I think just to refer to recommendation number 3 on Page 11, you recommend more institutional facilities for medical care to be brought into existence, and so forth, especially rehabilitation facilities and other facilities for the aged, chronically ill and mentally ill. What part would you expect to recommend that the Federal Government would take in bringing about these additional facilities that you recommend?

MR. CRYSLER: Pretty much the capital cost. It is a large question and really a political decision. But we would think most of the capital cost. As a Province is administering it perhaps would be a little more sensible to suggest that they should make whatever contribution they are going to make through operating supports. The Federal Government, as I understand, for constitutional reasons is most unlikely to administer, so I think it should make its contribution mainly in the form of capital, leaving the Provinces to administer.

THE CHAIRMAN: Then on this statement at the foot of Page 10: "Governments should channel financial aid towards aiding people in low-income groups or any others who for valid reasons are financially unable to provide themselves with protection against their medical care expenses." Would you care to spell that out a little more fully?

MR. CRYSLER: I think we would spell it



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THE CHAIRMAN: Then on this statement

at the foot of Page 19: "Governments should channel  
financial aid toward aiding people in low-income groups  
or any other way for valid reasons and financially  
unable to provide themselves with protection against their  
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a little more fully?

MR. CRYSTAL: I think it would still be





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out in rather large terms. We subscribe to the view that there is a standard of medical care that people should have, whether they are able to pay for it themselves. We believe that those who can pay for it themselves should pay for it themselves, and for those who cannot the Governments ultimately through tax sources should provide that care. Now, the mechanics of doing that ----

COMMISSIONER McCUTHEON: Provide the care or provide the money?

MR. CRYSLER: Really money, sir. The mechanics of doing it we have not gone into. It might be a direct sum of money.

THE CHAIRMAN: You accept very completely the proposition of the insurance industry?

MR. CRYSLER: On those who can pay, yes.

THE CHAIRMAN: They also accepted the principle that Governments at some level should make provision for those who cannot pay the premium.

MR. CRYSLER: Perhaps we would add a little side comment there by saying they are pretty much doing it now, why shouldn't they regularize it?

THE CHAIRMAN: You mean those on social aid?

MR. CRYSLER: Yes.

THE CHAIRMAN: We have heard a great deal of another class, those who are not on social aid, but who for one reason or another are unable to fully support themselves or, in the event of some illness or some unemployment or one of the various hazards of life,





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are not able to pay the premium that would have to be paid to obtain this minimum standard of protection that everybody appears to agree upon.

MR. McLEAN: Mr. Chairman, isn't it a fact that today, taking the hospital plan, that it is admitted that perhaps the amount does not carry the hospital, that the people are required --- I am speaking now of the Province of Ontario --- are required to pay the premium?

THE CHAIRMAN: Those who are employed in various groups?

MR. McLEAN: Yes. It is voluntary compulsion. But mind you, we are conscious of the fact that there are problems. But, first of all, people who are in the marginal class, and then there is another classification where there is a tremendous increase because of one particular illness. Now, to a certain extent that can be levelled off by insurance; they have plans which provide a substantial amount for a catastrophic expense. Now, we agree that there are problems of deciding at what stage the person looks after all of the health, of his own family and that of himself, and below that the Government should supply it. But the difficulty, we submit, is not that we should say throw everything overboard and everybody is brought into a state of prepaid medical plans.

THE CHAIRMAN: Do you think the intelligence of the community ought to be able to find a solution short of complete socialization? Is that what you are putting forward?



are not able to pay the premium that would have to be paid to obtain this minimum standard of protection that everybody appears to agree upon.

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THE CHAIRMAN: Do you think the

intelligence of the community ought to be able to find a point or sort of complete socialization? Is that what you are putting forward?



McLean 11699

MR. McLEAN: That is our position, yes. We are, of course, as a Board of Trade, opposed to socialization; that is one of the tenets.

THE CHAIRMAN: That is the base from which you start.

MR. McLEAN: Oh, definitely, yes.

COMMISSIONER McCUTCHEON: In some of the European plans substantial contributions are made by the employees under a compulsory wage-tax basis. On the happening of unemployment the State makes the payments, the premiums of those persons to the voluntary association.

MR. McLEAN: That would be a subsidizing of those individuals during that period.

COMMISSIONER McCUTCHEON: Subsidizing the individuals during the period of unemployment, in addition to whatever unemployment benefits they receive. Would you visualize that?

MR. McLEAN: That would be one method, because it would take care of large groups and leave administrative officials to take care of relatively few in relation to the total. But it is too difficult actually in this provision of collective agreements where monies are collected to pay for periods of unemployment, as I understand in some of the agreements, where a person ----

COMMISSIONER McCUTCHEON: The automobile workers.

MR. McLEAN: Yes, that is what I had in mind. There are tremendous problems and in the mechanics there are difficulties obviously, and we do feel that







McLean 2411700

there is something short of simply throwing everything into the State and saying everybody is under the plan. We think that is wrong.

COMMISSIONER McCUTCHEON: What would you say of the extension of the welfare principle? Let's say the unemployed would be taken care of, as I suggest, either through direct subsidization off the individual; it might involve higher premiums for unemployment insurance or collective bargaining which has produced this so-called -- I forget the name. Then there is this grey area. What would you say about an extension of the public assistance approach in which the three levels of Government would contribute and the test would be at local level?

MR. McLEAN: It would be a means test.

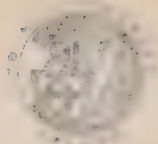
COMMISSIONER McCUTCHEON: That is right.

MR. McLEAN: Definitely, because there are certain people who might be quite able to pay their own way, and have been doing it, and then something is offered and it lifts a burden off their back, and then unless you have some control over it, you would have a large extension. Well, the old-age pension, as I recall, in its initiation was on the means test basis.

COMMISSIONER McCUTCHEON: Between 65 and 70 it still is.

MR. McLEAN: Yes.

COMMISSIONER McCUTCHEON: Have you given any particular thought to the mentally ill? They are not covered except under acute general hospitals.



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in its initiation was on the means test basis.

COMMISSIONER McCUTCHEN: Between  
\$5 and \$10 it still is.  
MR. McLEAN: Yes.  
COMMISSIONER McCUTCHEN: Have you  
given any particular thought to the retail bill? They  
are not covered except under acute general hospitals.



McLean 11701

They are not covered. Have you thought of their position?

MR. McLEAN: Yes. I think in a very general way we realize there is a tremendous field for treatment, say, out-patient treatment, and we say for the general good of the community the service should be extended, insurance and otherwise, and to involve the treatment of people in that category. I would say there are probably more mentally disturbed people outside of hospitals than inside.

COMMISSIONER McCUTCHEON: We are told about 40% of the beds in Canada are occupied by people who are mentally ill and the full problem falls on the Province and the standards are very definitely lower in those institutions than they are in your general hospitals. I am not asking you to give an answer now. If you haven't given any thought to that field, then say so.

MR. McLEAN: There is probably an intermediate area for the care of those people. From personal knowledge of the institutions involving the chronically ill people, there are a great many people occupying beds in those institutions who are mentally ill, it is not a physical condition, and it may well be that there should be some segregation. It may well be that a lot of them, due to age and injury --- it might be that the Government will have to assume a large responsibility.

COMMISSIONER McCUTCHEON: Let me put it this way. The Federal and the Provincial Governments having assumed, by and large, the responsibility for hospital



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McLean 11702

care, in-patient care, diagnostic care, and so on, with various methods of financing, but with many of the Provinces a completely tax-base, do you approve of the differentiation between the mentally ill and the physically ill in that setup?

MR. McLEAN: I am not at all certain that there should be any distinction. I am only speaking personally, and I think I carry a considerable number of people with me. If I am able to provide for my own physical illnesses, or operative procedures, why shouldn't I in a like manner provide for my own care?

THE CHAIRMAN: I don't think you are dealing with the question Commissioner McCutcheon put at all, Mr. McLean. We are dealing with hospitalization.

COMMISSIONER McCUTCHEON: The Province taking the responsibility for providing hospital care for physical illness in most of the provinces, without any premium or anything but a very nominal direct charge to the individual.

THE CHAIRMAN: On a cost-sharing basis, with the Province and the Federal Government dividing the cost 50% each way. They did not provide for mental illness in that formula.

MR. McLEAN: I think from the point of view of the mentally ill patients, I believe today that the individual, if he is capable -----

THE CHAIRMAN: We are trying to keep you on the track, Mr. McLean. We are asking you if you approve of excluding the patient in the mental hospital from that cost-sharing agreement or not?



McLellan 11702

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McLean 11703

MR. McLEAN: Well, as it comes out of taxes to a large extent, I can't see any reason why they should be excluded because I don't care what the tax base is, whether it is solely on a Provincial basis.

MR. CRYSLER: We recognize, gentlemen, that more provision of an institutional character must be made for the mentally ill. I think the first two sentences at the top of Page 4: "There is at present a shortage of institutional facilities in many parts of Canada. In particular, there is a special and general shortage of rehabilitation facilities and other facilities for care of the aged, chronically ill and the mentally ill."

THE CHAIRMAN: That doesn't take care of the share of the operating cost of these institutions.

MR. McLEAN: I think that is a matter for tax support.

THE CHAIRMAN: Tax support at the Provincial or Federal level?

MR. McLEAN: I would say at both levels.

THE CHAIRMAN: On Page 6 you refer to the Canadian Health Insurance Association proposition covering everybody, and perhaps one of the most significant suggestions put forward is that the industry would cover everybody regardless of age or pre-existing condition, and an agreed or stated maximum premium which it would be expected would not be sufficient, by and large, to cover the cost of insuring those classes, and that there would be a pool in which all companies would participate to support this maximum premium.



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4 I put the suggestion to the representa-  
5 tives of the Canadian Health Insurance Association for  
6 their view as to whether they thought the government  
7 might subsidize that pool to keep this maximum premium  
8 as a level at which people could pay. Have you got a  
9 view to express on that?

10 MR. McLEAN: I think perhaps we have  
11 expressed a view in the sense that the government would  
12 have to step in with respect to certain people, certain  
13 classes of people and make a contribution because they  
14 would be incapable of doing it themselves. Does it  
15 really much matter whether the premiums go on and on and  
16 on up for the support of those people, the ones who  
17 are not able to carry themselves. After all, both ways  
18 are a form of taxation, the implication is that somebody  
19 has to pay for it whether it is in the form of increased  
20 premiums or taxes and does it much matter?

21 THE CHAIRMAN: It is generally the  
22 taxpayer who pays the taxes.

23 MR. McLEAN: If everybody is insured  
24 then if you make an increase in premiums it would be the  
25 same as increasing taxation or the taxation rate. It  
26 is true when there are people not in the plan but if  
27 everybody is brought within the plan then it is pretty  
28 well ---

29 THE CHAIRMAN: I did not understand  
30 the plan as one that would bring everybody in, it would  
bring everybody in who wished to join, purely voluntary  
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4 if it were operated by industry unless you had legisla-  
5 tion.

6 THE CHAIRMAN: Well, thank you very  
7 much, gentlemen, for your views and for this brief.  
8 You have spelled out in non-medical language some of  
9 the ideas which the medical profession have been putting  
10 forward as to how a socialized system of medicine might  
11 affect the practice of medicine. As you appreciate,  
12 the views you have put forward are diametrically opposite  
13 to the views we have heard from other sources.

14 MR. McLEAN: We are conscious of that.

15 THE CHAIRMAN: That is why I think it  
16 is desirable that we should know as closely as we can  
17 the basis of your constituency, as it were.

18 MR. McLEAN: We will provide that  
19 information.

20 THE CHAIRMAN: Thank you very much.

21 THE SECRETARY: Mr. Chairman, the next  
22 brief is the submission of the Canadian Society for  
23 Clinical Chemistry and it will be known as exhibit 334.

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---EXHIBIT NO. 334: Submission of Canadian  
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Submission of Canadian

EXHIBIT NO. 384:





11706

SUBMISSION OF  
CANADIAN SOCIETY FOR CLINICAL CHEMISTRY

APPEARANCES: Dr. S. H. Jackson  
Dr. G. Nadeau  
Dr. D. B. Tonks

THE CHAIRMAN: Yes, Dr. Jackson?

DR. JACKSON: I have with me Dr. Nadeau from Quebec City and Dr. David Tonks from the Montreal General Hospital.

THE CHAIRMAN: I am happy to meet you gentlemen.

DR. JACKSON: This brief is submitted to the Royal Commission on Health Services by the Canadian Society for Clinical Chemistry. It presents the views and recommendations of its members regarding the practice of clinical chemistry from the point of view of obtaining the best possible health care for all Canadians.

The brief is presented in the following sections: I Introduction - containing general information and a description of the Society; II Areas of Work and Availability of Clinical Chemists; III Duties and Functions of a Clinical Chemist; IV Education and Training; V Quality of Workmanship; VI Research and Research Facilities; VII Professional Standing; VIII Salaries; IX Recommendations.

The following recommendations are made by the Society:-

COMMISSION OF  
CANADIAN SOCIETY FOR CLINICAL CHEMISTRY

Dr. G. M. Nadeau  
Dr. E. B. Toms

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The following recommendations are made

by the Society:-



1.                   Whereas many hospitals in Canada do not employ clinical chemists, and there is a definite need for one in every hospital, it is recommended that every hospital be required to have a clinical chemist on its staff, preferably full-time.

2.                   Whereas there are at present no established requirements or standards for clinical chemists, it is recommended that the standards to be soon established by the Certification Board of the Canadian Society for Clinical Chemistry be adopted as the minimum ones for this profession.

3.                   Whereas most clinical chemists have post-graduate degrees and therefore have been trained for research, and whereas there is a continuing need for research in the applications of chemistry to the practice of medicine, and whereas research is necessary for the proper operation of a biochemistry department, it is recommended that all hospitals of 300 beds or more be required to provide research facilities in their clinical chemistry departments. It is further recommended that these facilities be considered to be essential for the proper operation of a biochemistry department, and be recognized as part of the essential health services for the patient.

4.                   Whereas there is a need for an improvement in the quality of the work being produced by many clinical chemistry laboratories, it is recommended that an adequate quality control system be established in each of these laboratories, and that continuous efforts be made to improve the quality of



1. Whereas many hospitals in Canada do not employ clinical chemists, and there is a definite need for one in every hospital, it is recommended that every hospital be required to have a clinical chemist on its staff, preferably full-time.

2. Whereas there are at present no established requirements or standards for clinical chemists, it is recommended that the standards to be soon established by the Certification Board of the Canadian Society for Clinical Chemistry be adopted as the minimum ones for this profession.

3. Whereas most clinical chemists have post-graduate degrees and therefore have been trained for research, and whereas there is a continuing need for research in the applications of chemistry to the practice of medicine, and whereas research is necessary for the proper operation of a biochemistry department, it is recommended that all hospitals of 300 beds or more be required to provide research facilities in their clinical chemistry departments. It is further recommended that these facilities be considered to be essential for the proper operation of a biochemistry department, and be recognized as part of the essential health services for the patient.

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workmanship.

5. Whereas there is a shortage of clinical chemists in Canada, it is recommended that university training facilities for this specialty be expanded, and that incentives be increased in order to attract qualified personnel into the profession. It is recommended that these incentives include (a) salaries at levels reasonable for professional, scientifically-trained personnel, (b) classification at full professional rank in hospitals, and (c) adequate research facilities.

THE CHAIRMAN: Thank you, Dr. Jackson. I would think that your group would recognize that most of the subjects you have discussed are within the operation of a hospital or under provincial control or the matter of qualification, certification and recognition is an intra-professional matter. However, that does not mean that what you have said here is not of significance to this Commission and particularly with this recommendation that all hospitals of 200 beds or more be required to provide research facilities in their clinical chemistry departments. Would you care to spell that out how that can be accomplished?

DR. JACKSON: I think this is largely a matter of supplying area and personnel and equipment in the regular hospital budget that would be designated for research.

THE CHAIRMAN: Now, you take, apart from the teaching hospitals, are you making a distinction between the teaching hospital and a non-teaching hospital here?



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5. Where there is a shortage of clinical

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4 DR. JACKSON: No, I think not; I think  
5 all hospitals should have research facilities of this  
6 size.

7 THE CHAIRMAN: As you will appreciate,  
8 hospitals have only one budget upon which to operate  
9 and that is a budget that is accepted by the provincial  
10 hospital commission in whatever form that administration  
11 may take place in the various provinces. Would you  
12 involve in requiring a hospital to have -- to meet  
13 this recommendation?

14 DR. JACKSON: You mean in the way of  
15 personnel and so on?

16 THE CHAIRMAN: Personnel, the equipment  
17 budget?

18 DR. JACKSON: Well, I do not think  
19 this may be very expensive. Most of the hospitals  
20 have technicians designated for research, an area would  
21 not have to be large, an ordinary small laboratory area  
22 and the equipment need not be too expensive. We do not  
23 need probably \$10,000.00 pieces of equipment.

24 THE CHAIRMAN: Your most important  
25 factor is ---

26 DR. JACKSON: To have the time and  
27 to have the technical assistance to pursue this.

28 THE CHAIRMAN: You are clinical  
29 chemists and you are a trained doctor and then qualified  
30 in the specialty?

DR. TONKS: I think this is a point.  
There is a professional trained person they have who  
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4 necessary to have a good service and it is a shame it  
5 is really wasted. If you are going to attract a well  
6 qualified chemist into the area who could give a good  
7 service you have to give him some incentive. I think  
8 the incentive has to be, for one thing, research,  
9 providing him with these facilities and you will be able  
10 to obtained a highly qualified person.

11 THE CHAIRMAN: I may be merely not  
12 informed but is it a fact there is a biochemistry  
13 department in each hospital of over 300 beds?

14 DR. JACKSON: Oh, yes.

15 THE CHAIRMAN: Now?

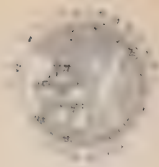
16 DR. NADEAU: And I would also add that  
17 the biochemistry section of the lab is the one that does  
18 most of the work in quantity if not quality. If it  
19 is expressed in units of work it is the biggest one in  
20 most hospitals as compared with bacteriology or pathology  
21 in the big hospitals 300 and over. Coming to the problem  
22 of research, I do not know if I understand the problem  
23 of my colleagues outside the City of Quebec but most  
24 of them have a Ph.D. degree.

25 THE CHAIRMAN: That is what I say, we  
26 are talking about highly qualified people.

27 DR. NADEAU: And these people go to  
28 an isolated hospital, mostly geographically and I think  
29 it is a waste of talent for them to do only routine  
30 requests. Their first duty is to wait for requests  
from ---

THE CHAIRMAN: I happen to be the  
chairman of a board of a hospital of over 300 beds and





necessary to have a good service and it is a shame it is really wasted. If you are going to attract a well qualified chemist into the area who could give a good service you have to give him some incentive. I think the incentive has to be, for one thing, research, providing him with these facilities and you will be able to obtain a highly qualified person.

THE CHAIRMAN: I may be merely not informed but is it a fact there is a biochemistry department in each hospital of over 300 beds?

THE CHAIRMAN: Now? DR. WADSWORTH: And I would also add that the biochemistry section of the lab is the one that does most of the work in quantity if not quality. If it is expressed in units of work it is the highest one in most hospitals as compared with bacteriology or pathology in the big hospitals 300 and over. Coming to the problem of research, I do not know if I understand the problem of my colleagues outside the City of Quebec but most of them have a Ph.D. degree.

THE CHAIRMAN: That is what I say, we are talking about highly qualified people.

DR. WADSWORTH: And these people go to an isolated hospital, mostly geographically and I think it is a waste of talent for them to do only routine requests. Their first duty is to wait for requests.

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Nadeau

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3 I did not think we had one. I was just checking with  
4 my chief of staff.

5 DR. JACKSON: Did you get lost in the  
6 department of pathology?

7 THE CHAIRMAN: Go ahead, Dr. Baltzar  
8 will discuss this.

9 DR. NADEAU: Probably in many hospitals  
10 it is quite a new field.

11 THE CHAIRMAN: I do not think we have  
12 one in either of the large hospitals in Regina.

13 COMMISSIONER BALTZAN: I support you  
14 on that.

15 DR. NADEAU: At least they are doing  
16 a lot of biochemistry and if you take out the bio-  
17 chemistry units from the rest of it you will be amazed  
18 at the amount of work done. If you will allow me I will  
19 go back to what I think should be the aspect of research  
20 by a clinical chemist rather than a biochemist. I  
21 think this man is a part of a teaching hospital and he  
22 is training and if he cannot have any academic research  
23 then he is training in purely an organic field. I  
24 would not like for him to have the whole research  
25 equipment to pursue his hobby but they are doing work,  
26 there is a lot to do in improvement of methods and  
27 he cannot do that by routine work. Certainly there is  
28 a lot of time he can afford while having an eye on  
29 routine for doing research, practical research for  
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Nadeau

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6 included in the hospital budget but we have some  
7 examples in Quebec where, for instance, they have had  
8 grants from M.R.C. They have the grants for technicians  
9 and equipment and what they need is space, really space  
10 and this should be thought about; should be included in  
11 the lab, the space, and should be allowed to do it in  
12 their contract.

13 THE CHAIRMAN: It may be accomplished  
14 in two ways. Your recommendation may be arrived at in  
15 two ways: first, by having the provincial administrative  
16 body, the Commission, accept this as part of the budget  
17 and then the Federal Government automatically would  
18 pay approximately 50% of the cost but if the provincial  
19 people were not willing to do that, then it would only  
20 be accomplished by making the grant conditional and  
21 you can appreciate just how difficult that would be.  
22 I mean just what kind of a problem that might bring  
23 about.

24 COMMISSIONER McCUTCHEON: Supposing  
25 tomorrow morning your first recommendation is put into  
26 effect, every hospital be required to have a clinical  
27 chemist on its staff; what percent of the hospitals  
28 would you make the provision for in Canada?

29 DR. JACKSON: You mean how many  
30 clinical chemists are there in Canada?

COMMISSIONER McCUTCHEON: You say there  
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DR. JACKSON: There would certainly be



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Jackson

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THE CHAIRMAN: There is not enough for Quebec or Ontario as individual provinces.

DR. TONKS: This could be handled by hiring one chemist for several hospitals on a temporary basis.

COMMISSIONER GIRARD: Dr. Nadeau, do you foresee any kind of co-operation in this research that would be done in all these hospitals starting with 300-bed hospitals, which is not a very large hospital? Would this research be done each on their own or would there be any kind of co-ordination?

DR. NADEAU: What we are trying to do in Quebec, a group of biochemists are doing some work on quality control, for instance, and this involves quite a large number of hospitals, exchange the results and everything.

By doing quality control you first probably look at existing methods and then someone improves upon the method or suggests a new one. This has happened.

COMMISSIONER GIRARD: There is some co-ordination? Every hospital is not doing a little piece of research on its own?

DR. JACKSON: No, it would not be isolated units. Then there is all the reporting of the research through the Society.

COMMISSIONER GIRARD: And this research done in the smaller hospitals can be tied up with a larger piece of research done in larger teaching





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Jackson 11714

hospitals?

DR. JACKSON: Yes.

DR. NADEAU: When you have been involved in research, it grows on you and stays on you. I can mention the coming program of the meeting that we are having next week in Quebec City of the Society, the annual meeting and if you look at the program you see that we have 18 papers done by people. Most of them have had no grants yet. They are mostly technical, the papers. Improvement on methods or new methods and I think they are courageous people to continue.

I have three papers only from Sherbrooke hospitals, which is not very many. They are doing some research work. Very modest; either on quality control or statistical investigation of certain fields of pathology in this region but they are doing it by the back door, if I can use this expression. Doing it without the hospital knowing.

If you have time to do research, we don't need you full-time.

COMMISSIONER GIRARD: You mean they are doing it on hospital time without any specific allowance for it?

DR. NADEAU: Yes. This should be recognized. At least the principle should be recognized. That is what I would ask first and then facilities.

DR. TONKS: In the larger hospitals this is probably not as easy to do because the chemist is so much busier. He just does not get time. Unless he has special personnel for this purpose he cannot do



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Tonks:

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COMMISSIONER GIRARD: But would every biochemist be research-minded?

DR. NADEAU: No.

COMMISSIONER GIRARD: You cannot say just by having a biochemist in the hospital that you are going to do research then?

DR. NADEAU: No.

COMMISSIONER GIRARD: You have to have a biochemist that is inclined or has some special facilities?

DR. NADEAU: The building and facilities last for quite a while longer than the chemist itself and if the chemist is not research-minded - a chemist is not eternal - I wouldn't say that this chemist is not research-minded so you won't provide for research facilities in this particular hospital.

DR. JACKSON: I would think it is the rare Ph.D. who is not research-minded because he has done research in the course of getting his degree. He has been introduced to it and usually the bug takes.

There is the rare exception who is not really research-minded who would rather do a routine job, but it is very rare.

COMMISSIONER GIRARD: Will the Ph.D. go to a small hospital or will he tend to go into the larger teaching hospital?

DR. NADEAU: May I speak for Quebec? The tendency now in Quebec is to get away from big centres because the Government has provided for solitude



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Nadeau

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bonus; to attract them outside of the big centres. Take, for instance, Chicoutimi, which is 125 miles from the university and it is a 950-bed hospital.

COMMISSIONER GIRARD: I think it's rather an exception.

DR. NADEAU: I think it is probably a poor example for the other reasons; I know what you mean. It all depends on the men who are there. Because the men are not prepared there, we will ignore all facilities in this hospital and block all the expansion; I do not think this is right.

COMMISSIONER BALTZAN: Gentlemen, really to start at the beginning, there are some practical points that you want to bring out. First and foremost I refer to the fact that you brought your subject up in order to introduce and press for the establishment of biochemical departments in hospitals. Am I right?

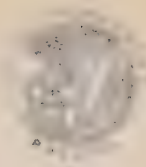
DR. TONKS: Yes.

COMMISSIONER BALTZAN: And then am I right that your work is now being done under the Department of Pathology by pathologists who are not so well-trained in just the biochemical portions of their activities?

DR. TONKS: This varies from hospital to hospital.

COMMISSIONER BALTZAN: Allowing for all that and we are talking about the same thing - we are being quite in the open - the pathologists in hospitals, serving most hospitals today, are primarily histopathologists and also have taken technical training,





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Nadeau

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Tonks 11717

some biochemical training in a lot of the procedures that he is doing.

DR. TONKS: That is true.

COMMISSIONER BALTZAN: This is no reflection at all on the pathologist; so am I right in saying that you are pressing forward to the establishment of such departments because this is perhaps the future of clinical advancement tying up the basic sciences with clinical medicine in the hospital.

That being the case, you are looking first and foremost, and I repeat, to the practical aspects and you have gone so far as to say that you advocate one biochemist to every 300-bed hospital. Can you tell us, at this moment, roughly the percentage of laboratory units which belong to the biochemists and the laboratory units which belong to the histopathologists in our present set-up in the hospital? I think somewhere in here you have some mention of it.

THE CHAIRMAN: Page 11.

COMMISSIONER BALTZAN: Is it 50/50?

DR. NADEAU: Out of all the units of the lab?

COMMISSIONER BALTZAN: Of what we call the laboratory units. There are very few hospitals that have biochemists.

DR. TONKS: I would say that in the smaller hospital it is almost 100% the pathologist technician team. In larger hospitals I would say it might be 50/50.

COMMISSIONER BALTZAN: The unit work

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Tonks

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Nadeau

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in that department is about 50/50?

DR. NADEAU: I am taking two examples here from Montreal Hospital and Quebec City Hospital. There are, in my hospital, about 400,000 units in the full lab and 200,000 of those come from biochemistry. The biochemistry is known as a section of the lab with biochemists.

COMMISSIONER BALTZAN: 50/50?

DR. NADEAU: Yes; and then in Montreal Paediatric Hospital I know that there are half-a-million units per year in that whole lab and out of that 325,000 comes from biochemistry.

THE CHAIRMAN: Three out of five there?

DR. NADEAU: Yes.

COMMISSIONER BALTZAN: In other words, you have established the point that if it is an essential part of the hospital and better under the control of appropriately-trained individuals, specifically for that purpose as against a makeshift?

DR. NADEAU: No reflection on the pathologist, of course.

COMMISSIONER BALTZAN: Without any reflection whatsoever.

DR. NADEAU: They ought to have chemistry training first.

COMMISSIONER BALTZAN: You really began to speak in terms of research. That is an ancillary portion of it?

DR. NADEAU: Yes.

COMMISSIONER BALTZAN: The appropriate



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Nadeau

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individual can initiate projects in a laboratory where he is working without necessarily setting up a whole machinery to start out on a research project. Am I right in saying that you derive your incentive in these hospital laboratories by, say, all kinds of cases that come along?

DR. NADEAU: That is right.

COMMISSIONER BALTZAN: So with your practical service to the hospital then comes along projects evolving out of the clinical occurrences in that hospital which lead you off into the investigative field?

DR. TONKS: Yes. I think this differentiates a bit in your basic or fundamental research where a person goes full-time into biochemistry research.

DR. NADEAU: That is what I mentioned before in saying that as I saw it he might be interested in, what I call, academic research. Actually I think topics of research are, and probably will come from contact with clinical problems.

That is what happened to me, as a matter of fact. I always spent all my life in a hospital, for 15 years after I got my Ph.D. I have published 60 papers at this time and they all have been inspired from clinical problems and we are able to appoint a clinical investigation unit.

COMMISSIONER BALTZAN: I appreciate your endeavours to take realistic action as concerns the hospital. As we see them today, this new department,





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Tonks

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5 reception on the part of hospital commissions and within  
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7 Canada in relation to the Act, the Hospital Insurance  
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9 DR. TONKS: Yes.

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COMMISSIONER BALTZAN: So that it is not likely, I ask you, that you can get anywhere with your recommendations, or your wishes, until this sort of thing is brought to bear upon our new hospital system?

DR. TONKS: That is right.

COMMISSIONER BALTZAN: If they do not recognize this, do not want to develop this, they will not provide for it, and things will go on as they are, so that is your first stumbling block?

DR. TONKS: I think perhaps there is one other factor. If a person does do very well in research, and he gets a lot of publicity from it, I think the hospital will then go along with it. You can do this from inside.

COMMISSIONER BALTZAN: Do not hospitals go along anyway, but I am thinking in terms of present limitations, circumscriptions. You are facing a new kind of situation. You, sir, have been working for a long time under a pre-existing condition.

DR. NADEAU: You mean the principles and the policies?

COMMISSIONER BALTZAN: That is in your hospital, where did you derive the support for your particular share of the work in that hospital?

DR. NADEAU: Do you mean in research?

COMMISSIONER BALTZAN: Practical applications and research. Where did you get your budgeting from?

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Nadeau 11722

difficult though.

COMMISSIONER BALTZAN: It is not included now?

DR. NADEAU: This was very difficult, and what happened, we had a new experiment ---

THE CHAIRMAN: I don't think Dr. Nadeau said it is not included now.

DR. NADEAU: No, we have a new experiment in Quebec, the Hospital Insurance Plan, and I think the wording of the Act, or the weights applied is that the Government said to the administrators of the hospital research is not included in the Act, and we cannot provide grants, and they interpret it as do not include research if you want your budget, and as I moved from one hospital to the other, I was only part-time at the time, they told me don't include any research. If you have time to do it outside of this, but please do not mention any research. The Act prevents the Government from drawing monies from the Hospital Insurance Plan, but I know they are not against it, as long as they don't pay for it. But they said don't mention even that you are using part of the locale for research.

COMMISSIONER BALTZAN: And you want to bring it to the surface here, because you are sneaking it in at the present time. Please excuse that word, because after all if you are making a certain number of tests, and you use hospital space and technicians and your own research faculties in interpreting and publishing that, you are doing research?

DR. NADEAU: Yes.



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and what happened, we had a new experiment ---

Nadeau said it is not included now.

DR. NADEAU: No, we have a new experi-

ment in Quebec, the Hospital Insurance Plan, and I think

the wording of the Act, or the weights applied is that

the Government said to the administrators of the hospital

research is not included in the Act, and we cannot provide

grants, and they interpret it as do not include research

if you want your budget, and as I moved from one hospital

to the other, I was only part-time at the time, they

told me don't include any research. If you have time to

do it outside of this, but please do not mention any

research. The Act prevents the Government from drawing money

from the Hospital Insurance Plan, but I know they are

not against it, as long as they don't pay for it. But

they said don't mention even that you are using part of

the locale for research.

COMMISSIONER BALTAN: And you want

to bring it to the surface here, because you are shaking

it in at the present time. Please excuse that word,

because after all if you are making a certain number of

tests, and you use hospital space and technicians and

your own research facilities in interpreting and publishing

that, you are doing research?

DR. NADEAU: Yes.



Nadeau 11723

COMMISSIONER BALTZAN: But you must not mention it?

DR. NADEAU: Yes, because they are afraid, the administrators of my hospital.

COMMISSIONER BALTZAN: I am not saying that critically. As I understand it you are here to bring the whole thing to the surface, and we might just as well call a spade a spade.

THE CHAIRMAN: I would think that the solution you are aiming at is you say the Act prevents it now, so you want the Act changed, so that it will be included?

DR. NADEAU: Our administrators understand that the Act is not against research, but they cannot provide against it.

THE CHAIRMAN: If the Act is deficient, that may well be within our terms of reference to make a recommendation to remedy a deficiency.

DR. TONKS: We have so many technicians who are doing routine work. We would also like one or two technicians who are allocated for research. So you can maintain your research facilities.

THE CHAIRMAN: You see, this is hospital administration.

DR. TONKS: Yes.

THE CHAIRMAN: All we can do is make suggestions about providing money and making it so that it is not impossible that money be provided. I just want to get your position clear, I mean, in my own mind, just what you are asking this Commission to do?







Tonks 11724

DR. TONKS: Well, I think perhaps the first thing is to recognize that research is needed in biochemistry departments.

THE CHAIRMAN: And therefore that making that submission that some procedure can be provided whereby it can be put into effect?

DR. TONKS: Yes, legally.

THE CHAIRMAN: Of course, yes.

COMMISSIONER BALTZAN: Under the terms of existing conditions, first it is very definitely recognized that you have a service, you know, that you do biochemical analyses, etcetera, but you are also incidentally and at the same time using up hospital time, as it were, for teaching, for keeping abreast of the advances, for introducing new methodologies, and that is being considered, that is being recognized. Certainly it is recognized by your hospital.

Is there any impediment, any interference with utilizing this time, although you are supposed to be providing practical services?

DR. TONKS: No, not as far as the senior personnel are concerned, but if we get someone to help, you say that you can do these things, I think this is the difficulty.

COMMISSIONER BALTZAN: That is where your stumbling block is?

DR. TONKS: Yes.

COMMISSIONER BALTZAN: But it is recognized?

DR. TONKS: Yes.



DR. TORRES: Well, I think perhaps the

biological department.

THE CHAIRMAN: And therefore that

making that submission that some procedure can be pro-

vided where it can be put into effect?

DR. TORRES: Yes, I believe.

THE CHAIRMAN: Of course, yes.

COMMISSIONER BATTAN: Under the terms

of existing conditions, first it is very definitely

recognized that you have a service, you know, that you

do chemical analysis, etcetera, but you are also

incidentally and at the same time using up hospital time,

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Is there any impediment, any inter-

ference with utilizing this time, although you are supposed

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DR. TORRES: No, not as far as the

service personnel are concerned, but if we get technical

to help, you say that you can do these things, I think

this is the difficulty.

Your stumbling block is?

DR. TORRES:

recognized?



Tonks 11725

COMMISSIONER BALTZAN: Lastly, gentlemen, and I hope I am making myself clear. I think we are sort of getting things straightened out in our thinking. The Chairman was quite right, that insofar as a certain locality that we are both acquainted with, there is no separation, or division of the departments of methodology where the hospital has a clinical biochemist, and there have been hopes for that, and wishes for it.

Now then, lastly, I see you point out on Page 12 a number of hospitals here. I haven't counted them, but as I glance at them I see that in these hospitals, hospitals having vacancies for clinical chemists, university hospitals and teaching hospitals, although some of them are, but for the most part there are no biochemists. Now, I expect that many of the university hospitals and teaching hospitals utilize the department of biochemistry to some extent, if not entirely, or do they?

DR. TONKS: They have until --- this is a changing trend. I think now this is most hospitals are providing their own biochemists now, the large ones, and getting away from this usage.

COMMISSIONER BALTZAN: If and when they can obtain them?

DR. TONKS: Yes.

COMMISSIONER BALTZAN: And they have gone to the point to realize that that work, even done by technicians, must be under the supervision of a qualified, competent individual?

DR. TONKS: Yes, the direct supervision.

COMMISSIONER BALTZAN: Direct, an





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on Page 12 a number of hospitals here. I haven't counted them, but as I glance at them I see that in these hospitals hospitals having vacancies for clinical chemists, university hospitals and teaching hospitals, although some of them are, but for the most part there are no biochemists. Now, I expect that many of the university hospitals and teaching hospitals utilize the department of biochemistry to some extent, if not entirely, or do they?

DR. TOLKS: They have until -- this is a changing trend. I think now this is most hospitals are providing their own biochemists now, the large ones, and getting away from this usage.

COMMISSIONER BALTAN: It and when they can obtain them?

DR. TOLKS: Yes. COMMISSIONER BALTAN: And they have

gone to the point to realize that that work, even done by technicians, must be under the supervision of a qualified competent individual?

DR. TOLKS: Yes, the direct supervision.



Tonks 11726

instructor in research? That is what your objective is?

DR. TONKS: Yes, if I may mention the Toronto General Hospital. In the last four or five years they have created a department of laboratories, in which all the former divisions of laboratories in the hospitals are combined into central laboratories, and put under the direction of a person qualified, and they have various divisions under him, and each of these again has a qualified person in charge, and they have in this way set up a series of laboratories for the hospital itself, which is separate from the university, although they do get a great deal of help from the university.

COMMISSIONER BALTZAN: Can you envision a separation of the biochemical from the histopathologic?

DR. JACKSON: In a number of hospitals their organization has separate departments.

DR. NADEAU: There are not many common problems between histopathology and biochemistry.

THE CHAIRMAN: Thank you very much, Dr. Jackson, Dr. Nadeau and Dr. Tonks. We think we understand your problem, and we will have it in mind as we go forward with our recommendations.

Now, we will have the submission of the Canadian Society for Clinical Investigation. This will be Exhibit No. 335.



instructor in research? That is what your objective is?

MR. TONKS: Yes, if I may mention the Toronto General Hospital. In the last four or five years they have created a department of laboratories, in which all the former divisions of laboratories in the hospital are combined into central laboratories, and put under the direction of a person qualified, and they have various divisions under him, and each of these again has a qualified person in charge, and they have in this way set up a series of laboratories for the hospital itself, which is separate from the university, although they do get a great deal of help from the university.

COMMISSIONER BAILLIEN: Can you envision a separation of the histopathology from the microbiology?

MR. TONKS: There are not many common lines organizationally in scientific departments.

MR. TONKS: There are not many common problems between histopathology and bacteriology.

MR. TONKS, Dr. Jackson and Mr. Tonks: We think we understand your problem, and we will have it in mind as we go forward with our recommendations.

Now, we will have the submission of the Canadian Society for Clinical Investigation. This will be Exhibit No. 88.





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---EXHIBIT NO. 335: Submission of the Canadian  
Society for Clinical Investigation.

S U B M I S S I O N O F  
THE CANADIAN SOCIETY FOR CLINICAL INVESTIGATION

APPEARANCES:

DR. J.C. LAIDLAW,

DR. D. BATES.

DR. LAIDLAW: My name is John Laidlaw.  
I am Associate Professor of Medicine at the University of  
Toronto, a clinical investigator and President of the  
Canadian Society for Clinical Investigation. My associate  
to my right is Dr. David Bates, Associate Professor of  
Medicine, McGill University. He too is a clinical  
investigator and a member and former councillor of the  
Canadian Society for Clinical Investigation.

With the Commissioner's permission we  
should like to read with some elaboration, the summary of  
conclusions and recommendations. We should like to preface  
this with a short introduction. Finally Dr. Bates wishes  
to make a few remarks concerning the relation between  
medical research and health care.

In the Introduction (pages 3 to 7) to  
the written submission it is indicated that clinical  
research or investigation is that aspect of medical  
research which is concerned with the direct study of  
disease in man. The life of the clinical investigator and



Submission of the Canadian  
Society for Clinical Investigation

---EXHIBIT NO. 385:

SUBMISSION OF

THE CANADIAN SOCIETY FOR CLINICAL INVESTIGATION

APPENDICES:

DR. D. BATES.

DR. LAIDLAW: My name is John Laidlaw.

I am Associate Professor of Medicine at the University of

Alberta, a clinical investigator and President of the

Canadian Society for Clinical Investigation. My associate

is Dr. David Bates, Associate Professor of

Medicine, McGill University. He too is a clinical

investigator and a member and former councillor of the

Canadian Society for Clinical Investigation.

With the Commissioner's permission we

will like to read with some elaboration, the summary of

our relations and research activities. We should like to present

the first part of the presentation. Finally Dr. Bates wishes

to read a few remarks concerning the relation between

clinical research and public health.

In the introduction (pages 3 to 7) to

the written submission it is indicated that clinical

research or investigation is that aspect of medical

research which is concerned with the direct study of

disease in man. The life of the clinical investigator and



Laidlaw 11728

the ways in which he may contribute to improvements in health care are also discussed. Because it is felt that clinical research will not be sound unless medical research as a whole is sound the submission of the Canadian Society for Clinical Investigation concerns the support of medical research in general and clinical investigation in particular in Canada. One final comment - it is suggested that more precise estimates of medical research needs with regard to construction of facilities in universities and hospitals could be obtained through the Deans of the 12 Canadian Medical Schools.

To turn to the Summary of Conclusions and Recommendations:-

1. This submission concerns itself largely with present support of medical research in general and clinical investigation in particular in Canada. Evidence is presented (paragraph 13) that the funds for this support fall far short of advancing requirements and lag considerably behind (calculated as per cent gross national product) comparable funds provided by the Federal Governments of Sweden, The United Kingdom and the U. S. A. It is estimated that approximately \$56,000,000 is required to meet the present needs of medical research (including clinical investigation) in Canada. The break down of this amount is indicated in the recommendations which follow.

2. Evidence has been referred to (paragraph 20) of the urgent need of medical research laboratory space in the universities. It is estimated that approximately \$30,000,000 is required now for this purpose. It is recommended that this amount be made available through





the ways in which he may contribute to improvements in health care are also discussed. Because it is felt that clinical research will not be sound unless medical research as a whole is sound the submission of the Canadian Society for Research in General and Clinical Investigation in particular in Canada. One final comment - it is suggested that more precise estimates of medical research needs with regard to construction of facilities in universities and hospitals could be obtained through the work of the 12 Canadian Medical Societies.

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2. Evidence has been referred to (paragraph 20) of the urgent need of medical research laboratory space in the universities. It is estimated that approximately \$30,000,000 is required now for this purpose. It is recommended that this amount be made available through



Laidlaw 11729

grants from both the Federal and Provincial governments.

3. Evidence has been presented (paragraphs 20,21) of the urgent need of clinical research space (laboratories and Special Investigative wards) in civilian teaching hospitals. It is estimated that approximately \$20,000,000 is required now for this purpose. It is recommended that this requirement be met through the Provincial Hospital Services Commissions. It is also recommended (paragraph 22) that the maintenance of Special Investigative wards in civilian teaching hospitals be the responsibility of the Provincial Hospital Services Commission.

With regard to items 2 and 3 it is recalled that three years ago the Farguharson Committee recommended that 37 million dollars be provided for the construction of medical research facilities in the universities and affiliated teaching hospitals. This recommendation has not been implemented. Moreover the 1959 estimates are now seen to be grossly inadequate.

4. Evidence has been presented (paragraphs 17,18) concerning present deficiency in number of established medical scientists in general and in number and security of income and tenure of established clinical investigators in particular.

For example it has been determined that approximately one half of the 187 established investigators in Canada lack security of income and tenure because they are being paid by granting agencies which provide no pension arrangements and to which re-application must be made every one to three years.



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grants from both the Federal and Provincial Governments.  
Evidence has been presented (paragraphs

27, 28) of the urgent need of clinical research space  
(Laboratories and Social Investigative wards) in civilian  
teaching hospitals. It is estimated that approximately  
\$20,000,000 is required now for this purpose. It is  
recommended that this requirement be met through the  
Provincial Hospital Services Commission. It is also  
recommended (paragraph 22) that the maintenance of

Social Investigative wards in civilian teaching hospitals  
be the responsibility of the Provincial Hospital Services

With regard to items 1 and 2 it is  
pointed out that three years ago the Commission on the  
Recommendation that 34 million dollars be provided for the  
construction of medical research facilities in the univer-  
sities and affiliated teaching hospitals. This report  
action has not been implemented. Moreover, the 1955  
estimates are now seen to be grossly inadequate.  
Evidence has been presented (paragraphs

17, 18) concerning present deficiency in number of  
established medical scientists in general and in research and  
teaching of medicine and surgery in clinical  
investigators in particular.  
For example it has been determined that approximately  
half of the 187 established investigators in Canada lack  
amount of income and research facilities

apportioned which provide no pension arrange-  
ments and to which no contribution need be made every year.  
These wages.





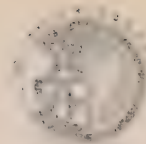
Laidlaw 11730

Sir, it is our belief that clinical investigators of the staffs of universities should have similar security of income and tenure as their colleagues in economics, biology and physics. That is not so in Canada.

To correct the lack of security of income and tenure of existing established clinical investigators would require over \$1,000,000 per annum. To correct the deficiency of established medical scientists as a whole would require approximately \$3,000,000 per annum. It is recommended that the latter amount be made available through an increase in the number of Medical Research Associateships (Medical Research Council) combined with the provision of further university posts through an increase in both Federal and Provincial government grants to universities.

5. Evidence has been presented (paragraphs 14, 15, 16, 19) of the following deficiencies in the present support of medical research including clinical investigation: insufficient number of summer undergraduate fellowships; insufficient stipends of medical research fellowships; inadequate funds for operating grants; and undue dependence, particularly for operating grants, on support from the United States of America.

A point of evidence in support of the latter statement is that for the year 1961-62 the funds provided by the National Institutes of Health and other sources in the U. S. A. for clinical investigation in Canada exceeded those granted by our own Medical Research Council. Much of our best clinical investigation is financed by these American funds.



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Sir, it is our belief that clinical

investigators of the staffs of universities should have similar security of income and tenure as their colleagues in economics, biology and physics. That is not so in Canada.

To correct the lack of security of income and tenure of existing established clinical investigators would require

of established medical scientists as a whole would require approximately \$3,000,000 per annum. It is recommended

that the latter amount be made available through an increase in the number of Medical Research Associations (Medical Research Council) combined with the provision of further university posts through an increase in both Federal and Provincial government grants to universities. Evidence has been presented (paragraphs

14, 15, 16, 17) of the following deficiencies in

the present support of medical research including clinical investigation: insufficient number of senior undergraduate fellowships; insufficient stipends of medical research fellowships; inadequate funds for operating grants; and inadequate, particularly for operating grants, as received from the United States of America.

A point of evidence in support of the

claim that the present support of medical research is

inadequate is the fact that the National Institutes of Health and other

agencies in the U. S. A. for clinical investigation in

Canada exceeded 100 million dollars in 1954-55.

Consequently, much of our best clinical investigation is

being carried out in the United States.



Laidlaw 11731

It is estimated that approximately \$3,000,000 per annum is required to correct these deficiencies. It is recommended that this amount be made available largely through the Medical Research Council.

6. It is suggested (paragraph 23) that the policy of the Medical Research Council regarding the administration of research funds should serve as a model for other agencies which support medical research.

7. It is suggested (paragraph 24) that local Clinical Research Advisory Committees, composed of representatives of medical schools and hospitals, would be helpful to advise Provincial Ministers of Health on those aspects of clinical investigation which may be financed by the Provincial Hospital Services Commissions.

8. No attempt is made to predict future needs of medical research including clinical investigation in Canada. It is considered (paragraph 25) that continually increasing funds will be required if Canada is to keep pace with rapidly advancing medical knowledge. Such funds must come in large part from government sources.





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4 Sir, I wonder if I might turn over  
5 to Dr. Bates.

6 DR. BATES: Sir, we noticed in the  
7 terms of reference of the Commission that in one of the  
8 items which came within your consideration, paragraph  
9 (j) in fact, of the categories (a) to (l), which states  
10 that you are concerned with "The relationship of existing  
11 and any recommended health care programs with medical  
12 research and the means of encouraging a high rate of  
13 scientific development in the field of medicine in  
14 Canada." In the case of category (k): "The feasibility  
15 and desirability of priorities in the development of  
16 health care services."

17 I should like to draw your attention  
18 to one important viewpoint in the matter of medical  
19 care. We have chronic disease and domiciliary care  
20 and all these important aspects. It might be forgotten  
21 that the major forward steps only occur as the result  
22 of research. In other words, if you and I have a choice,  
23 I suspect, sir, of providing large sums for domiciliary  
24 care and chronic disease, or finding a cure for the  
25 condition with the same amount of money, we would  
26 undoubtedly opt for the cure. It is often argued, our  
27 Society believes, that the major steps forward in the  
28 management and control and evolution ultimately of many  
29 of these chronic diseases is in research. Research is  
30 the root, we feel, and we have documented for you the  
viewpoint that perhaps insufficient attention has been  
given to the roots.

Now, as Dr. Laidlaw said, in the brief

Dr. BATES: Sir, we noticed in the  
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of research. In other words, if you and I have a choice,  
I suspect, sir, of providing large sums for chemotherapy,  
cure and chronic disease, or finding a cure for the  
condition with the same amount of money, we would  
probably opt for the cure. It is often argued, our  
policy is to believe, that the major steps forward in the  
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Bates

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4 we have shown that the United States is being extremely  
5 generous in supporting clinical investigation in Canada.  
6 There are many established Canadian investigators whose  
7 incomes are being paid entirely from Washington. I  
8 think that is a good thing in terms of encouraging  
9 inter-relationships between countries but a bad thing  
10 insofar as many of these developments should, I believe,  
11 now become part of Canadian responsibility.

12 THE CHAIRMAN: Well, gentlemen, in a  
13 very general way I wonder if we might have your reaction  
14 to this, as to whether what you are now proposing in  
15 the way of expenditure is something that has already  
16 been proposed to us from another angle, because we have  
17 heard from the medical colleges, various universities,  
18 we have had the submission from the faculties, several  
19 faculties, we had a submission from the Association of  
20 Medical Colleges which is just now coming into being,  
21 and all have pressed very strongly for increased amounts  
22 of money to be made available from government sources  
23 for research in Canada.

24 Now, have you studied, are you familiar  
25 with the other submissions to be able to say whether  
26 what you are now proposing today by way of expenditure  
27 is supporting what somebody else has already asked for  
28 or is this something new?

29 DR. LAIDLAW: Sir, I should say in  
30 principle, with particular respect to the Association of  
Canadian Medical Colleges, the two groups are in full  
agreement in terms of principle. We have chosen to spell  
out the way in which support may be split in certain areas

we have shown that the United States is being extremely generous in supporting clinical investigation in Canada. There are many established Canadian investigators whose incomes are being paid entirely from Washington. I think that is a good thing in terms of encouraging inter-relationships between countries but a bad thing insofar as many of these developments should, I believe, now become part of Canadian responsibility.

THE CHAIRMAN: Well, gentlemen, in a very general way I wonder if we might have your reaction to this, as to whether what you are now proposing is the way of expenditure is something that has already been proposed to us from another angle, because we have heard from the medical colleges, various universities, we have had the submission from the faculties, several faculties, we had a submission from the Association of Medical Colleges which is just now coming into being, and all have pressed very strongly for increased amounts of money to be made available from government sources for research in Canada.

Now, have you studied, are you familiar with the other submissions to be able to say whether what you are now proposing to lay by way of expenditure is supporting what somebody else has already asked for or is this something new?

DR. LAIDLAW: Sir, I should say in principle, with particular respect to the Association of Canadian Medical Colleges, the two groups are in full agreement in terms of principle. We have chosen to spell out the way in which support may be split in certain



Laidlaw

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4 as between the province and the dominion, and in certain  
5 cases of picking out particular areas we feel the  
6 provinces should assume full responsibility. That  
7 particular area concerns the hospitals themselves. The  
8 universities we have considered should be a shared  
9 responsibility, province and dominion. I would say we  
10 do not differ at all, and we have spelled out certain  
11 areas.

12 THE CHAIRMAN: I was only suggesting  
13 if it was duplication rather than difference, I mean  
14 support, parallel and strengthen.

15 DR. LAIDLAW: We would say parallel,  
16 support and strengthening.

17 THE CHAIRMAN: When you speak of certain  
18 things being done in regard to hospitals, are you  
19 suggesting that would be provincial only? I wonder if  
20 you have followed the matter through to the end, because  
21 hospital budgets today are split between the federal and  
22 the provincial, so that when you ask something to be done  
23 through the hospital you are in effect asking the federal  
24 government to contribute 50%?

25 DR. LAIDLAW: Yes, sir, that is correct.

26 DR. BATES: If I might add a word to  
27 that. I think one of the difficult problems with regard  
28 to clinical investigation is to understand how the  
29 support of it should be managed as between a central  
30 granting agency, the Medical Research Council, the  
31 university to which the hospital is attached, the hospital  
32 itself, in terms of hospital insurance acts, the province.  
33 We have suggested in this brief the responsibility of the





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Laibaw

as between the province and the dominion, and in certain cases of picking out particular areas we feel the

universities we have considered should be a shared responsibility, province and dominion. I would say we do not differ at all, and we have spelled out certain areas.

THE CHAIRMAN: I was only suggesting it was duplication rather than difference, I mean support, parallel and strenuous. Dr. LAIBAW: He would say parallel,

support and strengthening. THE CHAIRMAN: When you speak of central changes being done in regard to hospitals, are you suggesting that would be provincial only? I wonder if you have followed the matter through to the end, because hospital budgets today are split between the federal and the provincial, so that when you say something to be done through the hospital you are in effect asking the federal government to contribute 50%?

Dr. LAIBAW: Yes, sir, that is correct. Dr. BATES: If I might add a word to that. I think one of the difficult problems with regard to clinical investigation is to understand how the support of it should be managed as between a central granting agency, the Medical Research Council, the university to which the hospital is attached, the hospital itself, in terms of hospital insurance acts, the province. We have suggested in this brief the responsibility of the



Bates

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4 maintenance of some investigative beds would fall within  
5 the Hospital Services Commission's responsibility.  
6 Apart from that suggestion, it is the view of our  
7 Society that medical research money is best administered  
8 by such an organization as the Medical Research Council.  
9 I think they have learned in the United States that  
10 independent referees, as it were, sitting as an  
11 independent group, and following its quality, and so on,  
12 is still the best way to support medical research, and  
13 I think that our Society, by saying what we would like,  
14 feel that the policy that the Medical Research Council  
15 has followed is a model that is very much in mind.

16  
17 Simply giving a blanket amount of money  
18 for research is a pretty good guarantee that much of  
19 it will be ill-spent, and I think the most economical  
20 way of spending research money is through the Medical  
21 Research Council that other ways of spending tend to lead  
22 to poor quality work.

23  
24 COMMISSIONER McCUTCHEON: It tends to  
25 lead to duplication, too?

26  
27 DR. BATES: Yes.

28  
29 COMMISSIONER McCUTCHEON: You would  
30 contemplate a screening by referees, just as you have  
in the National Cancer Research Institute today.

31  
32 DR. BATES: Yes, that is quite true,  
33 sir. And although the amounts being administered by  
34 the national institution are very great, there has been  
35 so far in the United States no complaint of a monopoly.  
36 They have been so careful with the granting of money to  
37 scientific committees, there is no complaint there. Even







Bates

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3 though they are distributing millions of dollars, there  
4 is no accusation that they are doing this badly; they  
5 are doing it well.

6 COMMISSIONER McCUTCHEON: They use  
7 referees from the United States as well as from Canada.  
8 Do you see that taking place in clinical research, or  
9 is it such a personal matter?

10 DR. LAIDLAW: No, we think that  
11 principle would be applied across the board, including  
12 clinical investigation.

13 DR. BATES: There are Canadians who  
14 sit on the advisory boards there, too, sir.

15 COMMISSIONER McCUTCHEON: Yes, it  
16 works both ways.

17 COMMISSIONER VAN WART: Do you in your  
18 work notice a scarcity of library material for research,  
19 investigation?

20 DR. LAIDLAW: I don't know whether  
21 we are fully competent to answer that question, sir.  
22 I would perhaps say in the larger cities, such as Toronto  
23 and Montreal, the situation is not too inadequate. I  
24 don't think we can speak quite so well for smaller areas,  
25 and I don't think we are competent to do so, sir.  
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Bates

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H/dpw  
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4 DR. BATES: In my own area, which is  
5 Montreal, I cannot speak for smaller centres, it may  
6 be that library facilities are poor but I do not know  
7 the answer to your question.

8 COMMISSIONER VAN WART: Is your  
9 library material available for research workers in  
10 smaller communities?

11 DR. LAIDLAW: I could not speak for  
12 this province.

13 THE CHAIRMAN: You are dependent on  
14 the library that somebody else provides?

15 DR. LAIDLAW: Yes. For instance, in  
16 Toronto, the Academy of Medicine, which is affiliated,  
17 at least, with the university, as you know, provides  
18 a library service for much of the province in the  
19 clinical and research fields.

20 DR. BATES: I think, in Montreal,  
21 there would be no difficulty in anyone who introduced  
22 himself to the library making use of the medical  
23 library. It is normally used by undergraduates and  
24 faculty members but I have made arrangements for an  
25 American from northern New England to use the library  
26 and there was no trouble at all; it was just on a  
27 personal introduction basis.

28 THE CHAIRMAN: The medical librarians  
29 told us how widespread the loaning system was in  
30 Montreal and Toronto.

31 DR. BATES: Also through the States,  
32 our own library borrows from the library of Congress.

33 COMMISSIONER BALTZAN: Dr. Laidlaw,





DR. BATES: In my own area, which is

Montreal, I cannot speak for smaller centres, it may be that library facilities are poor but I do not know the answer to your question.

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DR. LAIDLAW: Yes. For instance, in

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COMMISSIONER BATES: Dr. Laidlaw,



Laidlaw

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you have heard a previous discussion with the people that preceded you; would you say that their aims and objects are a handmaiden to your aims and objects for this clinical investigation work?

DR. LAIDLAW: We would say that because research, particularly in the improvement of biochemical methods for the detection of disease, is a very important aspect of clinical investigation and we would support strongly research being done in that area by the people who presented that submission.

COMMISSIONER BALTZAN: Plus their other activities in the hospital?

DR. LAIDLAW: Yes, sir, I think it would be - we think it would be a great pity if people ---

COMMISSIONER BALTZAN: Dr. Bates, you spoke of the rate of progress towards medicine; would it be your concept, to paraphrase it in this way: without clinical research medicine, in 1982, might be the same as in 1960, roughly?

DR. BATES: Yes, I think that is fair.

COMMISSIONER BALTZAN: The idea is the same?

DR. BATES: Yes.

COMMISSIONER BALTZAN: Dr. Laidlaw, on page 1, paragraph 3, you say it is estimated that approximately \$20,000,000 is required now for this purpose and it is recommended that this requirement be met through provincial hospital services commissions. We are not talking about grants or other things; the Chairman has already referred to what that means, that



Laidlaw

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DR. LAIDLAW: We would say that

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COMMISSIONER BARTMAN: Dr. Laidlaw, you

said of the rate of progress towards medicine; would

it be your concept to prepare it in this way?

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the same as in 1950, roughly?

DR.

COMMISSIONER BARTMAN: The idea is

DR. BATH:

on page 1, paragraph 3, you say it is estimated that

approximately \$30,000,000 is required now for this

purpose and it is recommended that this requirement be

met through provincial hospital services committees.

We are not talking about health or other things; the

Chairman has already referred to what that means, that





Laidlaw

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it is not altogether provincial but it is hospital services and once you do this actually this would be added on to the cost of medical services, health services, treatment, unless it was put into a separate column or something like that.

Medical health services will cost \$20,000,000 more, that is a service to the people, the in and out-patients if and when you get this \$20,000,000. Is that the reason you mean that would be the case?

DR. LAIDLAW: This figure, of course, does not mean \$20,000,000 per annum; this \$20,000,000 concerns construction of research space in hospitals and that is the total amount we feel would be required now to bring things up to date in that respect. We agree that will obviously increase costs to the average person.

COMMISSIONER BALTZAN: In whatever way you bring it up, people should know these things are a part and that actually medical services costs themselves have not gone up?

DR. LAIDLAW: That is correct, sir.

COMMISSIONER BALTZAN: Thank you. Questions have been asked in relation to the problem of research and overlapping, etc., and one must be realistic and say that you cannot always avoid overlapping or duplication. However, there are two kinds of research: one is the fundamental basic science of research and the other is that for which you now make certain recommendations, and that is clinical research.



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are a lot and that actually medical services costs  
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OK, MAJORITY: That is correct, etc.  
CONSTITUTIONAL BARRIERS: Thank you.  
Questions have been asked in relation to the problem  
of research and over-education, etc., and one must be  
realistic. I'd say that you cannot always find things  
lacking or education. However, there are two things  
of research: one is the fundamental basic science  
research and the other is that for which you now make  
specific recommendations, and that is clinical research.



Laidlaw

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By clinical research you state that these aims may be achieved by the direct study of disease in man, that is clinical research. You state this on page 3 in the last paragraph and this is clinical research or investigation, study of disease in man as, shall we say, in test tubes. This is your definition of clinical research for which you are asking that amount of money?

DR. LAIDLAW: That is right.

COMMISSIONER BALTZAN: I will finish up by asking you this: if our understanding and if the people who think in terms of research in hospitals, yours are sick people, people upon whom you work and obtain this information but they are not used - I am putting words in your mouth - they are not used, by any means, as guinea pigs for your purpose?

DR. LAIDLAW: As you can understand, sir, direct study of disease in man creates certain amoral difficulties and the ethical standard of men who work in this area must be extremely high, if you like, the patient must come first and research must come second.

However, it is surprising and amazing to what extent one can look after a patient and study his disease for his benefit and for the benefit of those with that disease at the same time without harming that patient, helping him at the same time and learning something new about his condition for which the cause may not be known and for which there may be no good treatment.







Laidlaw

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COMMISSIONER BALTZAN: Really your observations on things that happen to people in the course of their illness, without doing anything about extracting, is the sum and substance of your observations and investigations?

DR. LAIDLAW: Yes, sir, but we would like to add one more thing; with the explosive advance in medical knowledge, it is now so much easier and more safe to apply these techniques to the study of disease in man without harming the patient than it was a few short years ago.

A great deal can be learned, both from using one's eyes and ears and through using these rapidly advancing special techniques of study which will not harm the patient.

COMMISSIONER BALTZAN: You have helped us a great deal an understanding the problem, thank you.

DR. BATES: Could I add to that two points? 85% of the membership of our Society are Fellows of the Royal College of Canada or equivalent, and the clinical investigator has to be in that clinical status largely because of the point you are indirectly making, that if he is, and I say this without a slur, if he is only a biochemist, his judgment as to what is and what is not a correct approach to a patient is less reliable than if he is also a Fellow of the Royal College of Physicians of Canada.

This double qualification the clinical investigator has to have; he has to be a physician of repute amongst physicians and a scientist among scientists.



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COMMISSIONER: Really your

observations on things that happen to people in the course of their illness, without doing anything about extracting, is the aim and substance of your observations and investigations?

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as a great deal in understanding the problem, thank you.

DR. BATES: Could I add to that?

perhaps 85% of the membership of our Society and Fellows of the Royal College of Canada or equivalent, and the clinical investigator has to be in that clinical status largely because of the point you are indirectly making, that if he is, and I say this without a slur, if he is only a physician, his judgment as to what is and what is not a correct approach to a patient is less reliable than if he is also a Fellow of the Royal College of Physicians of Great Britain.

This double qualification the clinical

investigator has to have; he has to be a physician of repute amongst physicians and a scientist among scientists.





Bates

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The second point is another thing I think is often forgotten, but in my own department we do no investigative work on patients using methods we have not already used on ourselves. The profession has a very honourable record of volunteer work on each other which is often disregarded. There are very few dangerous methods of investigation potentially like cardiac cauterization, which has not been used extensively on doctors before they are used on patients.

There are very few, and most of the methods which are used are used every day on ourselves as normal steps.

COMMISSIONER BALTZAN: Thank you.

THE CHAIRMAN: Thank you very much, gentlemen. We will take a short recess now.

--- Short Recess



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we do not investigative work on patients using methods  
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sively on doctors before they are used on patients.  
There are very few, and most of the  
methods which are used are used every day on ourselves  
as normal steps.

COMMISSIONER BALTMAN: Thank you.

THE CHAIRMAN: Thank you very much.

Gentlemen, we will take a short recess now.

--- Short Recess ---



R/hm

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THE SECRETARY: The next submission, Mr. Chairman, will be that of the Canadian Diabetic Association and will be known as exhibit 336. Dr. W. R. Feasby will present this submission.

---EXHIBIT NO. 336: Submission of The Canadian Diabetic Association.

SUBMISSION OF  
THE CANADIAN DIABETIC ASSOCIATION

APPEARANCES: Dr. W. R. Feasby  
Mr. Wallace Seccombe

DR. FEASBY: Mr. Chairman, Members of the Royal Commission, I am the Honorary Medical Director of the Canadian Diabetic Association and with me is Mr. Wallace Seccombe who has been president of our organization and who has accompanied me to speak for the lay part of our organization and who will read the recommendations, if he may.

THE CHAIRMAN: Remain seated if you will Mr. Seccombe.

MR. SECCOMBE: Mr. Chairman, Members of the Royal Commission, it is my pleasure to be here and present on behalf of the Canadian Diabetic Association our submission which was prepared by Dr. Feasby in consultation with members of the Executive of the Canadian Diabetic Association and in particular. Professor A.L. Chute of the Hospital for Sick Children and Mr. J.G. Coburn, our Vice-President.





THE SECRETARY: The next submission,

Mr. Chairman, will be that of the Canadian Diabetic Association and will be known as exhibit 336. Mr. W. R. Peasey will present this submission.

EXHIBIT NO. 336: Submission of The Canadian Diabetic Association

SUBMISSION OF

Mr. Wallace Peasey is

DR. PEASEY: Mr. Chairman, Members of the Royal Commission, I am the Honorary Medical Director of the Canadian Diabetic Association and with me is Mr. William Peasey who has been president of our organization and who has accompanied me to speak for the day part of our organization and who will read the document which, if he may,

MR. CHAIRMAN: Remain seated if you will.

of the Royal Commission, it is my pleasure to be here and present on behalf of the Canadian Diabetic Association your own submission which was prepared by Dr. Peasey in consultation with members of the executive of the Canadian Diabetic Association and in particular, Professor A. L. Chute of the Hospital for Sick Children and Mr. J. F. Johnson, our Vice-President.



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4 The submission is broken down into  
5 three parts. The recommendations are in the first part.  
6 Appendix 1 deals with the Association and its activities  
7 and Appendix 3 contains certain documents. I will  
8 simply read the recommendations which are contained in  
the first part.

9 Insulin was discovered in Toronto in  
10 1921 by two young Canadians, Banting and Best. It was  
11 developed in this country and manufactured here.  
12 Unfortunately advantage has never been taken of this  
13 commanding lead. Canada should lead the world in  
14 diabetic treatment, but in fact we lag far behind  
15 Scandinavia, the United Kingdom or the United States  
16 in the provision of facilities for the treatment of this  
17 disorder. This deficiency might be remedied by the  
following recommendations.

18 1. Diabetics represent close to 2% of  
19 the population of Canada. Whereas educational literature  
20 has been shown to be of great value in the care of  
21 diabetics and whereas The Canadian Diabetic Association,  
22 with the advice of experts, is in a position to prepare  
23 literature, it is suggested that governments, through  
24 their health agencies, should purchase quantities of  
25 such literature for distribution to diabetics. Appendix  
26 II - (4) shows the only document produced and paid for by  
27 government during the past nine years of which we are  
28 aware. A manual written by Canadian experts should be  
29 provided for every diabetic in Canada, since it would  
30 tend to keep them under better control, make them better  
employees and keep them out of hospital. Specific grants







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4 for translations into other languages in use in Canada  
5 should be made. (French, Chinese, Ukrainian, Italian, etc.)

6 2. diet counsellors for diabetics be made available in  
7 every city of more than seventy-five thousand inhabitants.

8 These dietitians should be associated with local  
9 hospitals; Hospital Service Commissions should give  
10 support to such dietitians, who would have special  
11 knowledge in the teaching of diabetics, preparation of  
12 special food, and would be able to advise hospitals of  
13 the district and practitioners in the area in the provi-  
14 sion of adequate dietary advice. Our organization is  
15 equipped to help administer such a programme and now has  
16 over twelve years experience in providing this service  
17 in co-operation with the medical profession. Each  
18 counsellor costs about \$12,000.00 per year.

19 3. Camping establishments for diabetics  
20 can be co-ordinated with those for other special groups.  
21 Funds to provide such units should be made available to  
22 provincial branches of the Association and grants to  
23 provide adequate supervision are most important. Twelve  
24 such camps would serve the needs of Canada at the present  
25 time and approximately one thousand children could be  
26 accommodated for a period of ten days to two weeks in  
27 each holiday season.

28 4. Board institutions for older diabetics  
29 should be supported by government. Boarding schools  
30 should be developed for children who are special problems  
or whose parents are unable to provide adequate care.

5. It is suggested that a registry of

For translations into other languages in use in Canada

should be made. (French, Chinese, Ukrainian, Italian, etc.)

2. We recommend that whole or part time

diet counselors for diabetes be made available in

every city of more than seven thousand inhabitants

These dietitians should be associated with local

hospitals; Hospital Service Commissions should give

support to such dietitians, who would have special

knowledge in the teaching of diabetes, preparation of

special food, and would be able to advise hospitals of

the district and practitioners in the area in the provi-

sion of adequate dietary advice. Our organization is

equipped to help administer such a program and now has

over twelve years experience in providing this service

in co-operation with the medical profession. Each

counselor costs about \$12,000.00 per year.

3. Special arrangements for diabetes

can be co-ordinated with those for other special groups.

Guides to provide such units should be made available to

provincial branches of the Association and grants to

provide adequate supervision are most important. Twelve

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time and approximately one thousand children could be

accommodated for a period of ten days to two weeks in

each holiday season.

4. Board institutions for older diabetes

should be supported by government. Special schools

should be developed for children who are special problems

or whose parents are unable to provide adequate care.

5. It is suggested that a study of



Seccombe

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4 diabetics might be maintained with assistance from the  
5 Department of National Health and Welfare. This could  
6 be linked with studies of heredity now being undertaken  
7 under The Family Tree Research Programme.

8 6. Special grants for the building of  
9 treatment and training centres should be made available  
10 through the Hospital Services Commissions. There is  
11 no question about the saving of active treatment beds  
12 that would result. If \$5,000.00 could be provided for  
13 each centre bed proposed in any community, fewer costly  
14 hospital beds for diabetics would be required. Well  
15 educated, well trained diabetics do not become ill  
16 and therefore stay out of hospital.

17 7. Whereas diabetes is a lifetime disorder  
18 and whereas several provincial governments have already  
19 provided testing materials and therapeutic agents to  
20 those in need, it is urged that all provincial govern-  
21 ments should provide all proven therapeutic agents,  
22 without charge, to those diabetics certified by their  
23 physicians as being unable to purchase them for  
24 themselves.

25 8. The funds for medical research in  
26 Canada are very limited and those for research into the  
27 basic problems of diabetes are inadequate. At least  
28 \$75,000.00 more per annum could be wisely spent on  
29 research projects, and should be made available through  
30 The Medical Research Council.

31 9. Since the taxation structure seriously  
32 affects the price of testing materials, it is recommended  
33 that treatment and testing materials be sold without tax  
34 for use by diabetics. It seems anomalous that government



... might be maintained with assistance from the Department of National Health and Welfare. This could be linked with studies of heredity now being undertaken under the Family Tree Research Programme.

... centres should be made available through the Hospital Services Commissions. There is no question about the saving of active treatment beds that would result. If \$3,000.00 could be provided for each centre bed proposed in any community, fewer costly hospital beds for diabetes would be required. Well educated, well trained diabetes do not become ill and therefore stay out of hospital.

... and whereas several provincial governments have already those in need, it is urged that all provincial governments should provide all proven therapeutic agents,

physicians as being unable to purchase their own. The funds for medical research in

Canada are very limited and those for research into the basic problems of diabetes are inadequate. At least \$25,000.00 more per annum could be wisely spent on research projects, and should be made available through the Medical Research Council.

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4 effort is devoted to provide care for patients in many  
5 ways, but a universal sales tax of 8% is imposed on all  
6 therapeutic and diagnostic materials with a few  
7 exceptions.

8 Mr. Chairman, we have amended the  
9 ninth recommendation slightly. I think there are one  
10 or two exceptions to the imposition of a sales tax.

11 We had it in here that there were no  
12 exceptions. I think there are one or two exceptions but  
13 in most cases sales tax applies.

14 THE CHAIRMAN: It is an interesting,  
15 perhaps minor and rather practical suggestion here,  
16 number 7 where you say that all proven therapeutic  
17 agents should be provided without charge to the diabetics  
18 certified by their physicians as being unable to purchase  
19 them for themselves.

20 You see that as a practical thing to  
21 make the physician the one who administers the means  
22 test?

23 MR. SECCOMBE: Well if we can take  
24 insulin as an example, I think it is practical, certainly,  
25 for the doctors to determine whether insulin is required.

26 THE CHAIRMAN: Oh yes, there is no  
27 doubt about that.

28 MR. SECCOMBE: Your question was  
29 whether it was practical to have a doctor --?

30 THE CHAIRMAN: To have a doctor certify  
whether he is able to pay for it or not.

MR. SECCOMBE: Oh, I see what you mean.  
I hadn't really thought of that. I would have thought

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MR. CHAIRMAN: Oh yes, there is no

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MR. CHAIRMAN: To have a doctor certify

whether he is able to pay for it or not.

MR. SECORD: No, I see what you mean.

I think we thought of that. I would have thought





Seccombe

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4 that because of the personal relationship between  
5 patient and his doctor that he perhaps would be well  
6 qualified.

7 THE CHAIRMAN: Speaking as a layman  
8 you think it would work?

9 MR. SECCOMBE: I believe definitely  
10 it would, yes. I can remember when insulin was first  
11 discovered. I don't know that this is too relevant,  
12 but when it was first discovered insulin was given I  
13 think to all patients. I was one of the early ones  
14 who took insulin. It was given to them all and then  
15 finally I think the doctors -- a revision was made. The  
16 doctors were asked to tell whether it was needed or  
17 not and finally I think the idea was abandoned altogether.

18 Regardless of who applies the means  
19 test, our feeling is very definitely that diabetic who  
20 is not able to afford insulin ---

21 THE CHAIRMAN: Should get it.

22 MR. SECCOMBE: Should get it. I must  
23 say we haven't given very much consideration to who  
24 applies the means test. I think in other Provinces  
25 perhaps Dr. Feasby could enlighten us but I think in  
26 other provinces the means test is applied by doctors. Is  
27 that not right?

28 DR. FEASBY: Mr. Chairman, there are  
29 quite a number of provinces, all but one I think where  
30 the doctor does apply the test where it seems to work  
quite satisfactorily.

THE CHAIRMAN: If it works satisfactorily,  
that is probably the best proof it is a good procedure.



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that not matter

quite a number of provinces, all but one I think where  
the doctor does apply the test where it seems to work

quite effectively.

that is possibly the best proof it is a good procedure.



Feasby

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4 DR. FEASBY: While it is true that  
5 insulin can be made available to patients in all but one  
6 of our Provinces on the doctor's recommendation, there  
7 are many other forms of insulin and many other forms  
8 of therapeutics which are not available and there are  
9 people who are unable to have provision of some desirable  
treatment just because of that regulation.

10 THE CHAIRMAN: Number 3, camping  
11 establishments. You go on to say "Funds to provide such  
12 units should be made available to provincial branches  
13 of the Association and grants to provide adequate  
14 supervision are most important." Does your thinking  
15 go as far as to say by whom? Are you thinking of  
Government here?

16 MR. SECCOMBE: Well I might say that  
17 the Canadian Diabetic Association is responsible now  
18 for sponsoring seven diabetic camps across Canada. Not  
19 enough, however.

20 THE CHAIRMAN: With more money you  
21 would be able to provide twelve. You think that would  
be a good number in Canada?

22 MR. SECCOMBE: Yes, that is right.

23 THE CHAIRMAN: Where do you think this  
24 extra money should come from?

25 MR. SECCOMBE: Perhaps Dr. Feasby would  
26 like to answer that.

27 DR. FEASBY: Mr. Chairman, the thought  
28 here is that Government might provide certain assistance  
29 by providing suitable sites or by allowing diabetic  
30 children to share a site that they have already allocated



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THE CHAIRMAN: I understand, coming to the question of the Government. You go on to say "I want to provide such units should be made available to provincial branches of the Association and grants to provide adequate supervision are most important." Does your thinking go as far as to say by whom? Are you thinking of Government here?

MR. SPOONER: Well I might say that the Canadian Diabetes Association is responsible for sponsoring seven diabetic camps across Canada. Not enough, however.

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MR. SPOONER: Yes, that is right.

THE CHAIRMAN: Where do you think this extra money should come from?

MR. SPOONER: Perhaps Mr. Tarnan would like to answer that.

DR. TARNAN: Mr. Chairman, the thought here is that Government might provide certain assistance by providing suitable sites or by allowing districts children to share a site that they have already allocated



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TORONTO, ONTARIO

Seccombe

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for some other group.

We do not think that it is an  
exclusive need.



for some other reason.

We do not think that it is an





Feasby 11751

DR. FEASBY: Some organizations are becoming interested. Many of our camps are now sponsored, and we feel that could be encouraged and developed.

The final point is that transportation of these children, for example, from the Lakehead say, to either one of the camps that now exist in Ontario, makes it virtually prohibitive for the family and for a young diabetic unit to bring the child down, and if that could be subsidized, or helped in some way by Government.

THE CHAIRMAN: Your idea is that the Association should continue to operate the camps?

DR. FEASBY: Should encourage their operation. I wouldn't say that we should have the exclusive privilege of operating them, because the best ones are operated with our encouragement, but by service clubs and so on.

THE CHAIRMAN: But by means of a voluntary organization?

DR. FEASBY: That is right.

COMMISSIONER STRACHAN: What is the special objective in having the camps for diabetics?

DR. FEASBY: Well, Mr. Chairman, I understand that the question is motivated by something which may have been heard about a difference of opinion, whether a diabetic child should be sent to a separate camp. The objective is to make an environment for him where he can do nearly all the things that a normal child would do at camp. He could not, or should not, be allowed to do those without very careful supervision, and we also feel that for a few years of his life, at a critical





Feasby 11752

stage of development, it is very important that he know there are others in the same boat.

We know of hundreds of examples in Canada of children who are rebellious and uncontrollable, who with one session of two or three weeks become quite controllable.

COMMISSIONER STRACHAN: Your premise is quite incorrect.

DR. FEASBY: I am sorry, but it is a matter of debate. Some people say we should not isolate them and make them different from other people, but this has been thought of very carefully, and we don't recommend it as a perpetual pattern, but at a certain stage they should go to one of these camps.

COMMISSIONER STRACHAN: What are your age limits for the children?

DR. FEASBY: From eleven, sir, until about sixteen. And I may say that many of these diabetic children have done so well that many of the counsellors in the camps are mature, seventeen and eighteen year old diabetics, who have mastered their personal disability, and who are a tremendous example to the youngsters coming up.

THE CHAIRMAN: We are told they also learn self-medication.

DR. FEASBY: They learn how to give themselves their own insulin, very early. Most of all they learn self-discipline.

COMMISSIONER BALTZAN: Just one question. You try and save money, and then on the other hand there is







Feasby 11753

the question to extend and expand. I notice that you advise a diabetic counsellor, say at \$1,200.00 a year.

My question is, are not hospital dietitians sufficiently trained to counsel, to prepare diets, to offer this kind of service, without taking on a new person, an official in respect to these services that you are advocating?

DR. FEASBY: In general the answer is that the dietitian has so much to do, and there are so few of them, that it is extremely difficult for her to devote the time that is necessary to the continuous training process for diabetics, and it has been our experience that when a dietitian is specially trained she becomes an extremely valuable member of the team that has to look after the diabetic patient, and she not only saves the hospital dietitians' time, but she saves the doctors' time, and of course the most important thing of all is that she saves the patient from getting into trouble. The diet is very frequently the most difficult problem that the family has to face.

COMMISSIONER BALTZAN: Would this counsellor serve several hospitals, or would a counsellor be attached to each fairly large-sized hospital?

DR. FEASBY: No, sir, we would consider that she should serve a whole area, a large group. In other words, she is a specialist who would serve ---- for example, the very first one we had did all of Ontario. Now we have one for the Western Provinces, and one for the Vancouver area, and so on.

COMMISSIONER BALTZAN: Counsellors or







Feasby 11754

dietitians?

DR. FEASBY: Both. They work very closely together.

THE CHAIRMAN: This opening statement, and then followed by Paragraph 1, is a very interesting statement. Can you offer any reason why none of this literature has been produced in Canada, except for this one pamphlet that you mentioned? I mean, did we merely become lazy, and borrow from someone else, or did nothing about it at all?

DR. FEASBY: It was not meant to indicate that we haven't produced a lot of literature. I was merely pointing out that Governments as such have not been very helpful in producing literature, and it is not for want of asking. Dr. Best himself went with me on two or three occasions to try to persuade the appropriate persons to help us, not to do it all, but to help us subsidize a manual for patients, or a diet manual, or to get it translated into French, or into Chinese. These are the people who very desperately need help, and it is very difficult to give, and so far we have not been successful.

THE CHAIRMAN: Do you think that that is the kind of a thing that can only be done effectively by Government?

DR. FEASBY: I feel that the cost is such, and that to do it privately with private translators is quite uneconomical, especially when our Government departments have facilities which they might turn to such an effort, without costing the tax-payer so much money.





Feasby 111755

THE CHAIRMAN: Once the manuscript was available, once the printed manuscript was available, the dissemination of it would be an easy matter for the Association?

DR. FEASBY: Very easy, because we have our diet counsellors, who for instance have to go out and try to teach the patient about the diet. The Chinese woman who knows hardly any English, and the only way we have been able to make any strides in this direction at all is to include pictures. And the same thing applies to this manual, which tells people how to live with their disease in simple lay language. If this, while it is well illustrated, could be converted into appropriate languages, the ones with whom we find the greatest difficulty in teaching, that would be a tremendous help. The big problems for us are Chinese, Hungarians, Italian. The French we can cope with, because the French Association in Quebec, which is separate, has taken our literature and of their own arrangement converted a lot of it into French.

THE CHAIRMAN: Now, would you expand on your opening statement that we lag far behind Scandinavia, the United Kingdom, and the United States in the provision of facilities for the treatment of diabetes?

DR. FEASBY: Yes, I would be glad to begin that, and Mr. Seccombe, as a layman, can follow me.

I mean simply that because it is a very unusual lifetime disease, and it requires the cooperation not just of a skilled health team, but of the patient and





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Feasby 11756

his family too, and it is very much easier to treat and to keep diabetics well-controlled if you have what has become to be known as a centre. It is a kind of treatment and training establishment if you like, where he is not a very sick patient. He is in almost a lodge kind of bed, something like the lodge at Mr. McCutcheon's Institute. It is a perfectly wonderful way to get people trained, if you can bring them into this environment, let them go on with their daily work, and come back for a check.

If a child develops diabetes, the mother comes with the child and lives in the institute or centre for several days and sees other people have the same problems, and gets the answers. There is a little model kitchen, and she finds out how to cook the food.

If you try to do this in the atmosphere of a doctor's office, or a hospital, you are wasting time and money, and we feel very strongly that we ought to have a lot of this kind of organization in key places in Canada. So far we have not been able to get it.

THE CHAIRMAN: Key places. How many places would you foresee?

DR. FEASBY: I think we should concentrate first on the teaching centres, because then you have all the best facilities for teaching and spreading the techniques of training diabetics. There is one such centre. It is not a separate unit, not a separate building, but it is a floor of the Royal Victoria Hospital, and it has been operating for about a year, but this is not ideal, because the patients are still going to the hospital, and they still resist it.



Twenty 11716

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and they still resist it.





Feasby 11757

It is not a very happy atmosphere for a diabetic who does not need that kind of care, and the reason we make the odious comparison is that all the countries we have mentioned have not one, but several of these. Little Denmark has two of them, beautifully, perfectly run.

THE CHAIRMAN: I suppose they haven't the transportation difficulties that we can foresee in Canada?

DR. FEASBY: That is right. We would have to have several.

COMMISSIONER McCUTCHEON: How big should such a unit be, how many beds, or dormitories?

DR. FEASBY: If one were thinking of Toronto, the initial size should be perhaps 50 beds. A centre started by Dr. Jolson in the City of Boston had, I think, 150 beds, but they began with only 25, some 35 years ago, and that seemed to serve the community very well, and indeed he served many Canadians with it too.

COMMISSIONER STRACHAN: What would be the average stay in an institution of that nature?

DR. FEASBY: The last time I visited Dr. Jolson, about a year and a half ago, I think he told me that mothers and children stayed about seven days, and new adult diabetics stayed about five days, and people who required adjustment, just that their treatment gets a little out of kilter, or not seriously ill, perhaps would only stay one whole day, not even a day and a night.

THE CHAIRMAN: Are they very expensive to operate? We have to foresee this in every province.



11757 Feasby

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Feasby 11758

DR. FEASBY: Yes, I would say that the fundamental cost is, for a personal service unit, would be about half, or much less than that, a third of the cost of a bed. We have done a good deal of estimating about this, Mr. Chairman, and we have a reasonable idea that it would cost about \$5,000.00 a unit. The per diem cost, I know, is certainly less than for an ordinary hospital patient, but we have not any experience in Canada to base it on.





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Feasby

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THE CHAIRMAN: Representing close to 2% of the population. So if we went to the Province of Manitoba, roughly a million population, you would finish up with about 20,000?

DR. FEASBY: Yes.

THE CHAIRMAN: And with that relationship you would think that 50 to 100 beds would look after it?

DR. FEASBY: I think it would, sir, because they don't all require help every year. Once they get off on the right foot, that is the important thing, the initial training period.

COMMISSIONER BALTZAN: Do you regard the Copenhagen Institute as a type of diabetic centre that you envisage?

DR. FEASBY: I was there last summer, Mr. Chairman, and I would consider that a very adequate training centre. Perhaps with a little bit more hospital atmosphere than we would hope would be necessary.

COMMISSIONER BALTZAN: One gets the impression that this is mainly a place for the most difficult types of cases.

DR. FEASBY: That is right.

COMMISSIONER BALTZAN: They need control rather than the average care and instruction, living conditions.

DR. FEASBY: The example we think of when we begin to talk of this is Johnson's own clinic that he conceived and developed and which I think does







Feasby

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both kinds of job admirably.

Now, when you get into difficult cases, gangrene, cardiovascular diseases, then dealing with the general hospital where all the facilities are available, we would hope that such centres would be close to the hospital where people would be transferred if difficulties arose.

THE CHAIRMAN: What transportation was provided in the Boston Clinic?

DR. FEASBY: None that I know of, sir. It is a private institution and people come there as private individuals, as far as I know.

THE CHAIRMAN: How would you go about your registry? You said it could be linked with the study of hereditary.

DR. FEASBY: Well, sir, if every diabetic and his family in Canada were to help us with the genetic research program which has just been inaugurated, we would eventually know the names, ages and, to some extent, the locations of all diabetics and this would be a tremendous help in the event of any type of emergency to the individual himself and to the people who have to plan to get the insulin to them, and it would enable the distribution of educational material to be much more specific, it would reach the target much more quickly.

THE CHAIRMAN: Do diabetic people show a tendency to congregate in any one area as distinct from another, depend on the accessibility of help?



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THE CHAIRMAN: Do diabetic people

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distinct from another, depend on the necessity of

help?



Feasby

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DR. FEASBY: I would say that there are more diabetics wherever there are more older people.

THE CHAIRMAN: Do they move, do they tend to go and live or to work in an area where they might get more help there than elsewhere?

DR. FEASBY: I have never heard of that. I would ask Mr. Seccombe if they feel that way.

MR. SECCOMBE: Mr. Chairman, I am glad we got back to the establishment of these centres, because as a diabetic I feel that of all these recommendations this is the most vital one. It is rather heartening to see that it is prepared by members of the medical profession and that the inadequacy of this country in this regard is acknowledged, medically, and I am sure that diabetics recognize this need.

Many diabetics, of course, are treated by general practitioners, because they cover a wide field of medicine, but perhaps not fully qualified where you get into difficult patients. A centre like this would provide an ideal centre even though they came from quite a distance, because they go into this centre and get treatment and then go back to the doctor who can look after them very well.

And certainly in Canada I think that clinically we are far behind. Scientifically we are way ahead because of the Best Institute, but clinically I think we are way behind.

The other recommendations here, of course, tie in with a centre, and we would hope that





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Feasby

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Seccombe

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the first one would be created in Toronto along the lines we visualize. But this, of course, would provide an ideal centre through which clinical research could be conducted.

One of the problems we have at the moment in connection with clinical research is that we have not got a specialized centre where proper clinical research could be conducted.

Mr. Chairman, I feel that the recommendations here would create centres and certainly the start with one right here in Toronto is the most significant recommendation in our submission. I am just speaking as a lay diabetic.

THE CHAIRMAN: Well, there is no question about its importance, when you speak of a group here of about somewhere between 350,000 and 400,000 people in Canada, that you are speaking about something that is of great importance, and we are very grateful to have the views of the Diabetic Association and the explanations and further assistance that you have been to us here this morning.

These recommendations and particularly your opening statement is rather a startling one, which I think we will deal with with our own research people and start to spell out what may be done. Your recommendations will be very much in our minds.

MR. SECCOMBE: Mr. Chairman, just as a matter of interest, wealthy diabetics very often go down to Boston, which, of course, irritates us; we feel we haven't got a place in Canada where we could go.





Seccombe

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So there is no question at all that we should have this type of centre.

COMMISSIONER VAN WART: Dr. Feasby, do you have any trouble, under the present circumstances, of getting your diabetic patients to the hospital for check-ups, and so on?

DR. FEASBY: Mr. Chairman, if I may answer Dr. Van Wart, I think all my colleagues who are in active practice find great difficulty when they attempt to do it from their own private offices. There is always a long waiting list for patients who haven't got emergencies nowadays.

MR. SECSCOMBE: It would be a great economic thing in a centre of this kind. This centre could handle them at, perhaps, half the price.

THE CHAIRMAN: We are very appreciative and cognizant of the recommendations you have made and appreciate you urging it as strongly as you have.





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COMMISSIONER VAN WART: Dr. Teasby,

do you have any trouble, under the present circumstances, of getting your anaesthetic patients to the hospital for check-ups, and so on?

DR. TEASBY: Mr. Chairman, if I may

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THE SECRETARY: The next submission, Mr. Chairman, is The Canadian Home and School and Parent-Teacher Federation, which will be Exhibit 337, and Mrs. Hewson will come forward for this submission.

--- EXHIBIT NO. 337: Submission of The Canadian Home and School and Parent-Teacher Federation.

SUBMISSION OF THE CANADIAN HOME AND SCHOOL  
AND PARENT-TEACHER FEDERATION.

Appearances: Mrs. G.C.V. Hewson  
Mr. D.M. Graham

MRS. HEWSON: Mr. Chairman, may I introduce Mr. Donald Graham, Director of Education for the Forest Hill Schools, Board of Education. The recommendations are found on page 4 of our brief.

IV RECOMMENDATIONS

1. That more adequate physical and mental health programs be provided for all children in school.
2. That mental health education (including child growth and development courses) for teachers in training institutions be made available and compulsory.
3. That facilities for Parent Education work in Canada be extended with emphasis on child growth and development, understanding of human behaviour and the basic needs of children.
4. That more marriage counselling centres with adequately trained staff be established.





Hewson

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5. That mental health education for student nurses, especially in the Public Health field, be added to the curriculum.

6. That standards for teacher selection and retention include consideration of mental health fitness. (See appendix, page 9.)

The Federation also recommends:

7. That a Mental Health Materials Centre be established for the purpose of receiving, preparing and evaluating mental health literature for the use of lay and voluntary organizations and such professional groups as may be interested. Such a service could be established by the federal government (Mental Health Division of the Department of National Health and Welfare) in collaboration with professional groups now working in the field of parent education and primary prevention and with voluntary organizations with professional staff.

8. That the Mental Health Division of the Department of National Health and Welfare undertake a modest study of the use and effectiveness of the Child Training pamphlets produced by the Division. These pamphlets are widely used and appreciated by Home and School (Parent-Teacher) groups who would welcome some guidance as to the most effective way of utilizing this material.

9. That Grants and Bursaries to teachers attending the Mental Health Training course for teachers now conducted by the Institute of Child Study, University of Toronto, be reviewed and increased.







Hewson

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That the health authorities inform Boards of Education annually of the value of this course and of the excellent work being done in Mental Health by its teacher graduates. (Section X, page 8)

THE CHAIRMAN: Mrs. Hewson, with your Recommendation No. 2, would you care to expand the reasoning behind that recommendation? What do you think a teacher who has had this additional instruction would do that is not now being done?

MR. GRAHAM: Mr. Chairman, I am particularly interested in this one aspect of the report, and I guess that is why I was invited here. It mentions that this training began in 1948. The Forest Hill Schools, of which I am the Educational Officer, was involved in the study and it brought teachers from all parts of Canada to Toronto for a year and they had three or four different kinds of experiences in training, and one was to try and identify at as early an age as possible mental health disability of children as they were seen in the classroom and at schools.

Secondly, in connection with this, there was a system of treating problems; and, thirdly, Drs. Seely, Mallinson, Lime, Griffin, designed a course called Teaching Human Relations in the Classroom, which was designed to give children and adolescents some self-understanding so that they could understand themselves and some of the problems that they would have to deal with in growing up.







M/hm

Graham

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4 Then, these teachers had experience in this identification  
5 work with the clinic, the teaching of human relations  
6 classes and their training also included a good deal  
7 of experience with facilities that were available in  
8 the community, mental health clinics and the psychiatric  
9 hospital and so forth. Now, the brief indicates there  
10 have been 80 teachers trained in this program and some  
11 of them have been doing some outstanding work. In our  
12 own system we have two, a public school principal and  
13 a young man who is a guidance counsellor in our  
14 collegiate and there is very encouraging evidence of  
15 the effect of this year of work with both these men,  
16 one in charge of the school and one doing counselling  
17 in a school. For a number of years I was on the board  
18 of the Provincial Mental Health Association and we  
19 tried very hard to foster this program and it seems to  
20 us that it was retarded because of the grant system.  
21 I know the two teachers who went from our school had a  
22 grant of \$2,500.00 and our board had to supplement this  
23 by paying their salary because otherwise they could not  
24 have maintained themselves for the year.

25 THE CHAIRMAN: Grants from whom?

26 MR. GRAHAM: It came through the  
27 Department of Health, the provincial Department of Health.

28 MRS. HEWSON: Mr. Graham has explained  
29 the special course for teachers but recommendation number  
30 2 refers more specifically to training in mental health  
education more along the line of child growth and  
development courses so they would have an idea what  
normal child behaviour is and they would feel more





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MR. CHAPMAN: Thanks very much.  
MR. CHAPMAN: It came through the Department of Health, the Provincial Department of Health.  
MR. NEWSON: Mr. Graham has explained the general concept for teachers but recommendation number 2 states no responsibility to training in mental health education and also the issue of child growth and development and so that would have an effect on mental health and so that they could help them.



Graham

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3 comfortable with children and would be able to establish  
4 a more stable emotional atmosphere in their classrooms  
5 and the children would be comfortable with the teachers.  
6 Children learn best when they are at ease in the  
7 classroom.

8 THE CHAIRMAN: Well, that is the  
9 education side and outside the ambit of this enquiry.  
10 We have heard from various people, particularly those  
11 concerned with the emotionally disturbed child that much  
12 could be accomplished if the teacher could recognize  
13 evidences of instability or emotional disturbances much  
14 earlier.

15 MR. GRAHAM: That is the purpose of  
16 this five-year study financing by the government and under  
17 the auspices of the Psychiatric Department of Psychiatry  
18 at the University of Toronto and the Canadian Mental  
19 Health Association to try and identify it at as early an  
20 age as possible. I think the evidence was quite con-  
21 clusive that the teachers are made aware of the problems  
22 at an early age and they can detect them and provide a  
23 climate of help that is needed.

24 THE CHAIRMAN: I was wondering if you  
25 had a view that that was as necessary in those educational  
26 systems in which you provide nursing services in the  
27 schools?

28 MR. GRAHAM: I think it would be very  
29 valuable. We have nurses in our school who work rather  
30 closely with students and I would feel that this kind  
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4 you had a duplication in having the teacher and the nurse  
5 both?

6 MR. GRAHAM: I would think it would be  
7 reinforcement rather than duplication.

8 COMMISSIONER GIRARD: I would just like  
9 to clarify this, when you are talking about situations  
10 especially in the public health field. Every public  
11 health nurse that is qualified as a public health nurse  
12 has had mental health in her curriculum, in her course.  
13 If you are speaking about students in the basic under-  
14 graduate course well, public health nursing is not part  
15 of that curriculum, only in a very few university  
16 schools where the students get a basic university degree  
17 but the public health nurse as such all have had mental  
18 health in their curriculum.

19 MRS. HEWSON: During the past year in  
20 the central Ontario area two groups of public health  
21 nurses have asked for additional training in child growth  
22 and development. They thought that was an important  
23 part of their public health service in their mental  
24 health training which apparently they did not get during  
25 their course of training. One group was in Simcoe County  
26 and the other was in Etobicoke.

27 COMMISSIONER GIRARD: They may want  
28 something additional but mental health is, per se, part  
29 of the curriculum?

30 MRS. HEWSON: Yes.

THE CHAIRMAN: As you will appreciate  
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Graham

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5 provincial scheme of things and not part of the enquiry  
6 entrusted to this Commission? However, we are interested  
7 in all phases of a subject which impinges on health  
8 services. Now, you refer to this study in paragraph 8  
9 and I assume from the opening statement that there are  
10 pamphlets provided; why would you want the people who  
11 have edited the pamphlets to evaluate them for us? Should  
12 not the evaluation be made by some other agency rather  
13 than the authors?

14 MRS. HEWSON: The way in which they  
15 are used, really we know from our own experience, at  
16 least we feel that to just broadcast these is of little  
17 value without preliminary preparation or follow-up  
18 discussion. The Canadian Home and School has prepared  
19 information to go along with these pamphlets and last  
20 year a member of the House brought up the question of  
21 the value of this service and suggested as an economy  
22 measure it ought to be dropped. We would like to see  
23 some study made for the best possible use for these  
24 pamphlets.

25 THE CHAIRMAN: Would you not accept  
26 for the Department of National Health and Welfare to go to  
27 the expense of producing them they must have made an  
28 initial decision that they were worthwhile and the matter  
29 of distribution must necessarily be in other hands?

30 MRS. HEWSON: Perhaps -- they are not  
distributed by the Department.

THE CHAIRMAN: They are just made  
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distributed by the Department.

THE CHAIRMAN: They are not made





Hewson

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MRS. HEWSON: Made available, yes.

THE CHAIRMAN: I think that covers the items upon which I would like some further explanation. Have you anything to add, Mr. Graham?

MR. GRAHAM: I appreciate your point, the relevancy of this to a frame of reference to a Commission. It does seem to me that these grants are initially given through the Department of Health, the provincial Department of Health and they are not adequate to bring teachers to expose them to this kind of training which research has shown is very valuable. This to me is the central point of my presence here. To that extent if there is an examination of this the grants are initially given by the Dominion Government.

COMMISSIONER McCUTCHEON: They are not matching grants?

MR. GRAHAM: I do not think so.

COMMISSIONER McCUTCHEON: In other words, it is not a case of the province holding back, you are simply saying the grant is not sufficient?

MR. GRAHAM: And even the teacher who can do this kind of work cannot come from Vancouver to Toronto and maintain himself because he is certainly a married man, for one year on \$2,500.00. This to me is the deterrent in getting people here to go at this kind of work.

THE CHAIRMAN: I want to thank you very much, Mrs. Hewson and Mr. Graham, for your brief and for your attendance and especially for agreeing to come forward out of turn to accommodate us in dealing





MRS. HEWSON: None available, yes

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Graham

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7 are grateful to you for having accepted our invitation  
8 to come at this time.

9 We will adjourn now until two o'clock.

10 ---Luncheon Adjournment.  
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IR/ss

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----Upon Resuming at two p.m.

THE SECRETARY: The first submission, Mr. Chairman, this afternoon is from the National Council of Women of Canada.<sup>19</sup> Dr. Bailey will present this brief which will be known as Exhibit 338.

---EXHIBIT NO. 338: Submission of the National Council of Women of Canada.

S U B M I S S I O N O F  
THE NATIONAL COUNCIL OF WOMEN OF CANADA

APPEARANCES:

DR. M. BAILEY, Chairman, Health Committee.

THE CHAIRMAN: Dr. Bailey, please?

DR. BAILEY: May I sit?

THE CHAIRMAN: Yes, indeed.

DR. BAILEY: Mr. Chairman, Members of the Royal Commission, it is a pleasure to present this on behalf of the National Council of Women which is an incorporated organization.

PREFATORY NOTE: The National Council of Women of Canada, an incorporated organization founded in 1893, comprises twenty-one nationally organized societies in federation, seven provincial councils and fifty-six local councils thus representing some seven hundred thousand women in Canada from coast to





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S U B M I S S I O N O F

APPENDICES:

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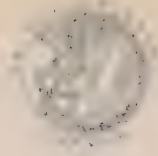
Bailey

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coast. Over the years, the National Council of Women of Canada has made submissions to Royal Commissions, other bodies of inquiry and Government after considered study of the subject or subjects under examination. Similarly, mindful of the import and possible effects of the Royal Commission on Health Services on a very large proportion, perhaps even on the total population of Canada, we submit this brief.

INTRODUCTION:

The history of the National Council of Women indicates that from time to time it has made submissions to Government emphasizing the importance of medical inspection of school children; of dominion-wide registration of nurses; of safe water and milk supplies; of the establishment of hospitals and sanatoria for specific needs. May it be mentioned that it was through the specialized interest and under the aegis of the National Council of Women that the Victorian Order of Nurses came into being, the value of which requires no comment. Together with the Health League of Canada, it was instrumental in bringing about the establishment of the National Department of Health. The National Council of Women has been effective, as well, in bringing into focus the implementation and stricter enforcement



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Bailey 11775

of the Narcotic Drug Act. Throughout the years, the Council has consistently concerned itself about maternal and infant care, as it has about mental health and tubercular patients.

OBJECTIVES: 1. Since it has been statistically in evidence that the most common cause of maternal mortality in the big cities is criminal abortions, most of which are performed on married women; and, with the accelerated growth of urban centres and the expansion of towns into urban complexes, the National Council of Women urges the continued study of this situation to expedite greater application of the laws to extirpate this malpractice from the Canadian scene.

2. Since many infant deaths occur in the first month or in the first year of life as borne out by the figures - of 485,022 infants born in Canada in 1960, 6471 were stillborn, 13077 died in the first year and 8410 died in the first month -

I might just mention there this is from the Dominion Bureau of Statistics 1960.

The National Council of Women urges the Commission to recommend the necessity for greater dissemination of information and wider use of whatever techniques are possible to lower the infant mortality rate in Canada.





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CONCLUSIONS:

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Bailey

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3. On the estimate that 45% to 50% of milk now consumed in Canada, in one form or another, is still unpasteurized and since raw milk carries disease germs, the National Council of Women asks the Commission to recommend action urging all provinces to bring about compulsory pasteurization.

4. The National Council of Women commends the Government on its recent legislation to provide more aid for the rehabilitation of mentally and physically disabled persons and requests the Commission to plead for the continuing recognition and extension, if need be, of help and assistance.

CONCLUSION:

In concluding this submission, the National Council of Women of Canada wishes to express its appreciation of the opportunity afforded it of setting forth its views on these very few issues. Recognizing that it is a voluntary organization, it has refrained from commenting on a wide conspectus of concerns but rather has exposed those areas in which definite stands have been taken by the large membership as a whole.

It is the earnest hope of the Council that the deliberations of the Commission will be productive of results that are far-reaching in their benefit to Canadians generally.

THE CHAIRMAN: Dr. Bailey, have you any further comment to make or additional to what you have read?



11776 Bailey

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Bailey

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DR. BAILEY: Well, it does not specify germs here. ... Could be germs of septic sore throat and bovine TB and typhoid fever in raw milk. And Canada's maternal mortality as far as other countries is concerned, stands about fourth and infant mortality stands about twelfth. I think that is all I have to add.

THE CHAIRMAN: Have you been following the figures, Dr. Bailey, since the inclusion of Newfoundland in the Dominion in relation to infant mortality? The figures were rather bad.

DR. BAILEY: Newfoundland is quite high.

THE CHAIRMAN: There is a very decided improvement there, which may affect these all Canadian figures.

DR. BAILEY: In the 1961 statistics of Newfoundland the maternity was at the rate of 36.

THE CHAIRMAN: But that was away down from ten years before?

DR. BAILEY: It would bring the whole thing down. Is that what you mean?

THE CHAIRMAN: Yes.

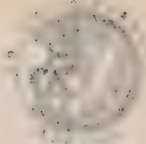
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THE CHAIRMAN: A vast improvement is going on in Newfoundland and is going to affect the whole picture?

DR. BAILEY: Yes, but that was 1961. That was pretty high, because Ontario is 24.

THE CHAIRMAN: I think ten years ago it was a hundred.





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Bailey 11778

DR. BAILEY: That might be. I don't know about the past.

COMMISSIONER GIRARD: Dr. Bailey, on this first part of your brief the first objective is to try to reduce the number of abortions. Do you have any information on whether these abortions are made --- we have heard in some of the hearings about these small hospitals, small maternity hospitals that are often unlicensed or not registered and we have the impression that most of these small hospitals are where these abortions are being carried on. Do you have any information about that?

DR. BAILEY: I don't know about that, but I might say that the Ontario Medical Association has been carrying on a survey in Ontario as far as maternal mortality is concerned and it may come out in that. I couldn't say.

COMMISSIONER STRACHAN: Where do you get the statistical evidence referred to here regarding it?

DR. BAILEY: It was from a report of the Ontario Medical Association investigation. An interim report.

THE CHAIRMAN: As I understand it, these cases come to the attention of the medical people after the trouble has arisen.

DR. BAILEY: That is right. Mostly.

THE CHAIRMAN: Mostly in terminal cases. That, of course, is criminal law enforcement.

DR. BAILEY: That is right.



11778

Bailey

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Bailey 11779

THE CHAIRMAN: It is rather interesting your observation here that some of us may not have known, that you were instrumental in the organization of the Victorian Order of Nurses.

DR. BAILEY: That was some years ago.

THE CHAIRMAN: "You" meaning your predecessors?

DR. BAILEY: Yes.

THE CHAIRMAN: We hear a great deal of the tremendous work that the Order has been doing in Canada, almost across the country. You speak here of pasteurization. I wondered that Dr. Strachan did not bring up the question of fluoridation. Have the Council of Women been able to take any stand or have they taken any stand on it?

DR. BAILEY: They have taken a stand inasmuch as a resolution was passed that they would work for it. It has not been taken to any Government and these are just things that have been taken in the past.

THE CHAIRMAN: The subject has been before them?

DR. BAILEY: They have taken a stand in favour of fluoridation of water a number of years ago.

THE CHAIRMAN: Now, in connection with number 4 on Page 2, in connection with mentally and physically disabled persons, has the National Council of Women given consideration to the fact that under the Hospitalization and Diagnostic Services Act cost-sharing program between the Dominion Government and Provinces excludes mental care? Have you anything to put forward on that?





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pastoralization. I wondered that Dr. Strachan did not  
bring up the question of filiofiliation. Have the Council  
of Women been able to take any stand on how they take  
any stand on it?

inasmuch as a resolution was passed that they would work  
for it. It has not been taken to any Government and those  
are just things that have been taken in the past.

THE CHAIRMAN: The subject has been

DR. BAILEY: They have taken a stand  
in favour of filiofiliation of water a number of years ago.

THE CHAIRMAN: Now, in connection with  
number 4 on Page 2, in connection with mental and  
physically disabled persons, has the National Council of  
Women given consideration to the fact that under the  
Hospitalization and Diagnostic Services Act not-allowing  
program between the Dominion Government and Provinces  
excludes mental care? Have you anything to put forward on



Bailey 11780

DR. BAILEY: Yes. They have considered it, but, as I say, it has not been taken to Government, but they feel that it should be included in the Dominion projects.

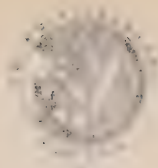
THE CHAIRMAN: We may add the volume of the National Council of Women to those who feel that it should not have been excluded and should now be included?

DR. BAILEY: That is right.

COMMISSIONER BALTZAN: I have no questions, Dr. Bailey. I do want to comment that you very clearly demonstrate leadership, extensive voluntary organizations and I have counted major steps forward that you have shown on Page 1 here, and it is commendable.

Perhaps I could append to that and ask what your attitude is to the current and prevailing popular opinion that Government should take immediate initiative and leadership in health service?

DR. BAILEY: Well, I cannot speak for the National Council of Women as far as that is concerned, because it has not been taken up in an overall picture. They have studied it, yes. I would not like to make a statement.



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Bailey

11781

AG/dpw

COMMISSIONER BALTZAN: You wouldn't want to see this activity that you people have carried on over the years since 1893 vanish?

DR. BAILEY: Oh, no.

THE CHAIRMAN: Yes, but one is not exclusive of the other?

COMMISSIONER BALTZAN: You would like it tied in?

DR. BAILEY: Well, I am not making a statement because it has not been taken up as far as the National Council of Women are concerned.

COMMISSIONER STRACHAN: I wonder if Dr. Bailey would like to explain to the Commission what the principal barriers have been to pasteurization in the various provinces?

DR. BAILEY: I don't know that I could answer that. There are only the two provinces that have it; Ontario and Saskatchewan.

COMMISSIONER STRACHAN: What effort has your Council made in the other provinces?

DR. BAILEY: Different provincial Councils have attempted to have something done. I would think, I am not sure of this, but I think it is New Brunswick or one of the Maritimes, has recently been working on it on a provincial level and one of the others, but I don't recall which one.

COMMISSIONER STRACHAN: The efforts have not been very fruitful so far?

DR. BAILEY: No. Of course, just a short time ago a neighbouring province had a typhoid





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Bailey

COMMISSIONER STANLEY: You wouldn't

want to see this activity that you people have carried

on over the years since 1887, wouldn't you?

DR. BAILEY: Oh, no.

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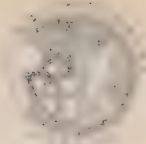
Bailey 11782

outbreak which was traced to milk, just a few years ago.

THE CHAIRMAN: That is the kind of thing that brings it very much to the fore, isn't it?

Well, thank you very much, Dr. Bailey. We will have this before us, and thank you for coming.

DR. BAILEY: Thank you.



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THE SECRETARY: The next submission, Mr. Chairman, will be that of the Canadian Association of Radiologists, and Dr. Gill will introduce the group to the Commission and also speak on the method of presentation of their submission. This will be known as Exhibit No. 339.

--- EXHIBIT NO. 339: Submission of the Canadian Association of Radiologists.

SUBMISSION OF THE CANADIAN ASSOCIATION  
OF RADIOLOGISTS.

Appearances: Dr. Guillaume Gill  
Dr. Ross A. Lobb  
Dr. R. Brian Holmes  
Dr. William L. Sloan  
Dr. Jean Bouchard  
Dr. Richard J. Walton

DR. GILL: Mr. Chairman, Madame, the Canadian Association of Radiologists wishes to express its appreciation to the Royal Commission on Health Services for the privilege of being allowed to present its brief. After a great number of sessions and even at this stage in its deliberations, the Commission has undoubtedly achieved one great accomplishment, namely, that each body appearing before it will have reviewed its means and purposes.

We can assure you that this Association has done its share of soul-searching in attempting to put forward its observations and recommendations for the best interest of Canadian citizens. We are sympathetic to the Commission's position of having heard repetitious themes presented by various bodies with





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Gill

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We will attempt to explain, Mr. Chairman, radiology is somewhat unique among the specialties of medicine, in that it deals with both diagnostic and treatment facilities and we have thought it desirable to prepare the brief in these two themes separately in the hope that this form of presentation will help to clarify certain pertinent matters.

---(Speaks in the French language)

On my right is Dr. William L. Sloan, Vice-President of C.A.R., on the staff of the Shaughnessy General Hospital, Vancouver. Dr. Sloan will present the preamble to the brief, pages 1 to 4.

Dr. Brian Holmes restricts his practice to diagnostic radiology at the Toronto General Hospital. He is on the Faculty of the University of Toronto. Dr. Holmes will present the summary and recommendations of the diagnostic section, pages 5 to 8.

Dr. Ross Lobb, also on the staff of the Toronto General Hospital, and of the University of Toronto, who also serves three community hospitals.

On my left is Dr. Jean Bouchard,



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Gill

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Radiation Therapist on the staff of the Royal Victoria Hospital, and of McGill University, Montreal. Dr. Bouchard will present the summary and recommendations of the therapeutic section, pages 24 to 26.

Dr. Richard Walton, Radiation Therapist on the staff of the Winnipeg General Hospital and the University of Manitoba. Executive Director of the Manitoba Cancer Foundation, and President of the National Cancer Institute of Canada.

DR. SLOAN: Mr. Chairman and members of the Royal Commission: since this brief is, to some extent, divided into the two sections, we request permission, sir, to read the preamble and the two sets of summaries and recommendations before any questions may be addressed to the group.

THE CHAIRMAN: The procedure suggested by Dr. Gill is quite acceptable.

DR. SLOAN: This submission is from the Canadian Association of Radiologists. It is a society of physicians, specializing in the diagnosis and treatment of disease through the use of X-rays and radioactive substances. It is affiliated with the Canadian Medical Association. It holds annual scientific meetings, publishes a quarterly scientific journal - the JOURNAL of the Canadian Association of Radiologists (Appendix I), and supervises the training and qualifications of radiologists and also of X-ray technicians.

2. In 1961 there were 578 radiologists in Canada (certified by the Royal College of Physicians and Surgeons of Canada), of whom 447 were fully qualified





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Sloan

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members of the Association. Many radiation physicists and radiation biologists are associate members of the Association.

3. The Canadian Association of Radiologists is organized by divisions. The Province of Ontario has four divisions, the Province of Quebec three divisions, and the other eight provinces one division each. The radiologists in each division elect a councillor. The Council is the administrative body of the whole Association and meets twice a year. The Association as a whole meets once a year.

4. An indication of the status of Canadian radiology in the world medical field is the fact that in August of this year, Canada, under the sponsorship of our Association, will be the host for the Tenth International Congress of Radiology. We anticipate registration of approximately 4,000 radiologists, physicists and biologists from all over the world.

5. A number of the committees of our Association do important work in the field of health. For example, our Committee on Training and Qualifications works closely with the Royal College of Physicians and Surgeons of Canada regarding training, qualifications, examinations and certification of specialists in radiology. Our Committee on Radiological Technicians works closely with the Canadian Medical Association and the Canadian Society of Radiological Technicians in the training of technicians in both diagnostic and therapeutic radiology. Our Committee on Standards, Units and

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DEFINITION OF RADIOLOGY

6. Radiology is a branch of medical science which deals with the uses of ionizing radiation in the diagnosis and treatment of disease. Radiologists are graduate physicians with a minimum of four years' post-graduate training in their specialty. It should be stressed that radiology is a specialty in the practice of medicine. Radiologists are not simply purveyors of a special kind of technical service. They are licensed medical specialists and act as medical consultants, seeing patients referred to them by their medical confreres, conducting and interpreting the results of radiological examinations to arrive at a diagnosis, and treating diseases with X-rays and radioactive substances. As licensed physicians, they are entitled





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Sloan

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to all the privileges of specialists in other branches of the profession, and they accept the responsibilities attached to those privileges. They should be treated under the same terms and conditions as other medical specialists.

7. The responsibilities of radiologists include:

- a) The care of the patients while they are in the department of radiology.
- b) The supervision and/or performance of the diagnostic and/or therapeutic procedure which has been decided upon.
- c) Interpreting and reporting the results of the diagnostic and/or therapeutic radiological procedure.
- d) Discussion and consultation with the patient's physician or physicians relative to the diagnosis and treatment of the patient.
- e) The specialized training of young radiologists.
- f) The training of young general practitioners and young doctors in other specialties in the principles of radiology.
- g) The training and supervision of technicians, nurses, stenographers and orderlies.
- h) Clinical and basic research in diagnostic and therapeutic radiology.



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i) Participation in ward rounds,  
staff meetings, refresher courses, etc.

j) Participation in medical board  
and other administrative meetings  
dealing with hospital problems.

k) The physical layout of the depart-  
ment.

l) The selection and maintenance of  
the equipment.

m) Health education to lay groups.

8. Radiology is divided into two  
specialties - diagnostic and therapeutic - by the  
Royal College of Physicians and Surgeons of Canada  
which, with the Canadian Association of Radiologists,  
controls qualification, training, examination and certi-  
fication of specialists in either or both fields.

9. Radiology is a relatively new  
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discovery of X-rays in 1895. Until fifteen or twenty  
years ago, a radiologist practised both types of radio-  
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progressively greater division into the two types of  
practice, and today they are virtually separate special-  
ties. Approximately 82 per cent of Canadian radiologists  
confine their practice to diagnostic radiology, 12 per  
cent to therapeutic radiology, and 6 per cent practice  
a combination of diagnostic and therapeutic radiology.  
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L/hm

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Doctor Holmes will present the summary and recommendations of the diagnostic section.

DR. HOLMES: Mr. Chairman and Members of the Commission:

1. It is explained that "radiology" is the practice of medicine and not a technical or hospital service.

2. The practice of radiology is described, indicating that it is carried out in the private offices of specialists in radiology and other physicians, as well as in hospitals of all sizes.

3. The training and qualifications of Canadian radiologists is shown to be of high quality. The role of the Canadian Association of Radiologists, in co-operating with other medical bodies, indicates our interest in maintaining a high standard of training in this specialty.

4. It is shown that the present number of diagnostic radiologists in Canada compares very favourably with the radiologist:population and radiologist:physician ratios in other countries. There is an increasing demand for radiological services, and of increased utilization of this type of medical care, under various medical services insurance programmes. The number of radiologists certified as specialists by the Royal College of Physicians and Surgeons of Canada over the past six years indicates that the supply is barely sufficient to keep pace with the increased demand for the complexity of services.

5. It is noted that because of geographic and population factors, there is urban centralization of



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radiology, as of other medical specialties. However, the provision of radiological services to the population of Canada would appear to be at least as good as for any other specialties.

6. The continuing high quality of radiological services is dependent not only upon the qualifications of the radiologist, but on conditions of practice and on work load. Excess work load leads to deterioration in quality of professional services and is best prevented by a method of professional remuneration which allows an income geared to work performed.

7. It is pointed out that the cost of hospitalization would be decreased by extending radiological benefits of voluntary health-care plans to out-patients, utilizing the services of radiologists in private-office practice as well as those in hospital.

8. It is indicated that there is an ever-increasing demand for radiological services, necessitating a commensurate supply of radiological technicians.

9. It is pointed out that the demand for radiological services has increased rapidly in the post-war period. There is also an ever-increasing need for additional space, supplies and equipment.

10. The total cost of radiological services in Canada has been estimated on an annual basis.

11. We indicate that research in radiology is mandatory. We note the need for funds, particularly for equipment, as well as a sufficient supply of radiologists from which to recruit research workers.



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12. We point out the need for priorities in the development of medical-care services, with particular reference to the provision of adequate space and personnel.

#### RECOMMENDATIONS

The Canadian Association of Radiologists recommends to the Royal Commission on Health Services:

1. THAT health-care plans acknowledge "diagnostic radiology" as a specialty in the practice of medicine and not as a hospital service.
2. THAT a high priority be given to methods for insuring an adequate supply of students in medical schools and of specialists-in-training.
3. THAT any health-care plans make specific provision for the maintenance of high quality training of radiologists.
4. THAT measures be taken to assure that "diagnostic radiology" remains in a position to compete with other specialties for an adequate number of physicians - to embark on post-graduate training in this specialty. Such measures would include the removal of diagnostic radiology from hospital insurance schemes, facilities be made available for research and investigation, and that adequate space and equipment be made available for the practice of clinical radiology.
5. THAT present methods of supplying radiological services to thinly populated areas be specifically provided for in health-care plans.
6. THAT the payment of a fee for each service performed supplies the most satisfactory means of



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5.

THAT present methods of supplying radiological services to thinly populated areas be significantly provided for in health-care plans.

6.

THAT the payment of a fee for each service performed supplies the most satisfactory means of



Holmes

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remuneration for diagnostic radiologists, and is the most likely to ensure the highest possible quality of service.

7. THAT hospitalization costs be reduced by making the fullest possible use of out-patient facilities, whether they be in a hospital or a private office, and to that end we recommend further:-

8. THAT the voluntary pre-payment medical-care plans be encouraged to continue and to expand their provision of more comprehensive coverage.

9. THAT measures be taken to ensure an adequate supply of career technicians by the maintenance of adequate training schools and the establishment of realistic salary scales in line with positions of similar responsibility in industry.

10 THAT sufficient funds be made available to enable radiological departments to keep abreast of medical advances, by securing sufficient equipment of the proper type, and that there be realistic periods of time for amortization of this specialized medical equipment.

11. THAT stress be placed on planning for sufficient space in radiological departments in hospitals to maintain the proper balance with bed capacity.

Mr. Chairman, Dr. Bouchard will continue and present the summary and recommendations of the therapy division.

DR. BOUCHARD: Mr. Chairman, Members of the Commission, in regard to therapeutic radiology, the practice of therapeutic radiology is described,

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remuneration for diagnostic radiologists, and is the most likely to ensure the highest possible quality of

7. THAT hospitalization costs be reduced

by making the fullest possible use of out-patient facilities, whether they be in a hospital or a private

office, and to that end we recommend further:-

8. THAT the voluntary pre-payment

medical-care plans be encouraged to continue and to expand their provision of more comprehensive coverage.

9. THAT measures be taken to ensure an

adequate supply of career technicians by the maintenance

of adequate training schools and the establishment of

realistic salary scales in line with positions of similar responsibility in industry.

10. THAT sufficient funds be made available

to enable radiological departments to keep abreast of

medical advances, by securing sufficient equipment of

the proper type, and that there be realistic periods of

time for amortization of this specialized medical

equipment.

11. THAT stress be placed on planning for

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to maintain the proper balance with bed capacity.

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Bouchard

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noting the developments over the past fifteen years which have considerably widened the field of work to be covered.

2. Medical Services - A description is given of the four broad systems under which the services of a therapeutic radiologist, his assistants and his facilities are presently provided in Canada.

3. Attention is drawn to the results achieved in British Columbia by a mass cytological screening programme, directed towards reducing the incidence of invasive cancer of the cervix.

4. A table is attached giving the number and category of radiotherapists and clinical radiation physicists in each province. This is compared with the minimum number required, as suggested by the National Cancer Institute of Canada Report entitled "Standards for Radiation Therapy Centres." An assessment is made of the extra number of radiotherapists required in five years' time, in consideration of the population

5.0 ~~1.0~~ and The reasons for the present shortage of radiotherapists are explored.

6. THE OLD WAY It is pointed out that clinical research is a present function of most of the centralized cancer treatment centres. In addition, the larger centres also carry out research in the basic science fields bearing on the cancer problem. It is suggested that building space for clinical research has lagged behind the need. While Federal and Provincial Cancer Control Grants are available to subsidize the workers and provide equipment, money for the shell of a building has





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4 to come largely from private donations. Private donors  
5 appear more willing to subscribe towards equipment,  
6 or a definite research project, rather than provide a  
7 building and its maintenance in which such work can be  
8 carried out. Attention is also drawn to the lack of  
9 full-time workers in clinical research and the reasons  
for this are discussed.

10 RECOMMENDATIONS

- 11 1. The present strong tendency towards  
12 centralization of the non-surgical treatment of cancer  
13 should be encouraged, but with the realization that there  
14 will be a need to continue the other existing systems for  
15 several years to come.
- 16 2. To provide non-surgical cancer treatment  
17 economically and to maximum benefit, new cancer-treatment  
18 centres should be established ideally to serve a population  
19 group of not less than 500,000, although this figure  
20 may be reduced in consideration of the population  
distribution found in Canada.
- 21 3. It is recommended that the present  
22 system of matching Federal and Provincial Cancer Control  
23 Grants be continued, but increased in keeping with the  
24 ever-expanding volume and complexity of cancer treatment.
- 25 4. Encouragement should be given to expand  
26 the present training facilities for cytological  
27 technicians considerably. The training of cytological  
28 technicians is entirely the responsibility of the  
29 pathologists, but radiotherapists are vitally concerned  
30 with the help that cytology can give to their patients.

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#### RECOMMENDATIONS

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system of watching Federal and Provincial Cancer Control Grants be continued, but increased in keeping with the ever-expanding volume and complexity of cancer treatment. Encouragement should be given to expand

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technicians is entirely the responsibility of the

pathologists, but radiotherapists are vitally concerned with the help that cytology can give to their patients.





Bouchard

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5. Considerable economy could be achieved by encouraging rapid expansion of minimum-care facilities within existing hospitals, or provision of hostel-type accommodation close to the hospital, for patients undergoing radiation therapy, and at present occupying active treatment hospital beds. The provision of the provincial hospital insurance scheme should apply equally to out-patients, as to in-patients, insofar as the benefits of treatment are concerned.

6. To attract more Canadian doctors to therapeutic radiology, greater use should be made of present radiotherapy facilities for the teaching of undergraduate students and junior internes in the management of cancer patients. An estimate of the number of radiotherapists whose services will be needed in the next five years should be arrived at, and such information should be made available to undergraduate students and internes for guidance and orientation. It is recommended that adequate remuneration be paid to the radiotherapist-in-training, be adapted to the current rates in various centres across the country, and be comparable to that of trainees in other specialties.

7. Radiotherapists recommend that the most desirable system of administering the cancer control programme, financed by federal and provincial grants, is by an independent commission on which the radiotherapist has adequate representation.

8. The present system of Federal and Provincial Cancer Control Grants exclude their use for construction of a building, apart from the extra amount





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Bouchard

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involved in radiation protection. It is recommended that consideration be given to widening the scope of the Federal Cancer Control Grant to include construction of special facilities for clinical research and special training, as well as treatment, to supplement the presently inadequate amount available from private, provincial and municipal sources. Thank you.

THE CHAIRMAN: Thank you, Dr. Bouchard.

Dr. Gill, your brief is a very complete one, but there are still one or two areas that we would like to explore a little further with your help and there are some questions that we would like to put, and you may have them answered as you see fit and by whoever you may want to designate.

DR. GILL: Yes, sir.

THE CHAIRMAN: On page 7, number 4, you say:

"That measures be taken to assure that  
"diagnostic radiology' remains in a  
"position to compete," et cetera.

You go on to say:

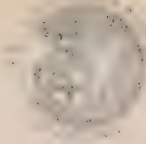
"Such measures would include the  
"removal of diagnostic radiology from  
"hospital insurance schemes...."

Just what is involved there in that?

At present under The Hospital Insurance Diagnostic Services Act I take it that diagnostic radiology is covered as one of the included services?

DR. GILL: Yes.

THE CHAIRMAN: And you say that that



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like to explore a little further with your help and there are some questions that we would like to put, and you may have them answered as you see fit and by whoever you may want to designate.

THE CHAIRMAN: On page 7, number 4,

you say:

"That measures be taken to ensure that

"position to compete," at least.

You go on to say:

"Such measures would include the

"removal of diagnostic radiology from

"hospital insurance schemes...."

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Services Act I take it that diagnostic radiology is

covered as one of the included services?

THE CHAIRMAN: And you say that that





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3 should be taken out of an included service?

4 DR. GILL: Doctor Holmes would answer  
5 that question, sir.

6 DR. HOLMES: Mr. Chairman, this is  
7 probably an idealistic point of view which has been set  
8 down here. We realize this is something that the people  
9 of the country are now provided with.

10 THE CHAIRMAN: That is what I was  
11 thinking. It is rather difficult to take away having  
12 given.

13 DR. HOLMES: Yes. We don't suggest  
14 it be taken away unless some other method of providing  
15 the same service can be given; and we have further down,  
16 I believe, suggested that as the voluntary plans continue  
17 to evolve and cover ever greater numbers of the population  
18 they would be in a position to take over this function.  
19 We might quote as an example, I think, in the Windsor-  
20 Ontario area under Windsor Medical Services there is a  
21 very large percentage of the population now covered,  
22 and if the time arrives when that number is approximately  
23 equal to the number who are covered for hospitalization,  
24 then we would feel that radiology should be made a part  
25 of the medical service insurance rather than hospital  
26 service insurance, because it is a service that can be  
27 carried out in a hospital or physician's office.

28 THE CHAIRMAN: This would mean lower  
29 costs under the Hospitalization and Diagnostic Services  
30 Act?

DR. HOLMES: That is right.

THE CHAIRMAN: And a pretty well





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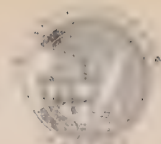
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TORONTO, ONTARIO

Bouchard

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corresponding increase under the insurance feature?

DR. HOLMES: That is right.



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DR. HOLMES: That is right.



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I was looking at Page 21 to see what that might come to. In Paragraph 71, where you say that there is one radiological examination by a certified radiologist for every four persons in Canada or approximately four and a half million a year at an average cost of \$10.00 to \$12.00 an examination. This would appear, if this recommendation is accepted, to add a load of some \$45,000,000.00 to \$60,000,000.00 a year to the insurance premium that would have to be collected if we were going on a basis of a premium-based scheme.

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DR. SLOAN: This would not be entirely the addition of a load, the examinations are being done and it would be a transferrance.

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THE CHAIRMAN: I appreciate it would be virtually the same amount of money, but what we have been hearing much of is that premiums which, if we go to a premium prepayment system, that the premium, there is complaint that the premium is going to be too high for people to pay. This is the objection of all those who object to the premium system is that only so many would be able to pay it, others would not be able to pay it at all, and some would be able to pay part of it.

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DR. LOBB: I think this \$45,000,000.00 to \$60,000,000.00, a large amount is already paid for in voluntary plans.

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THE CHAIRMAN: I would be wrong in thinking this \$45,000,000.00 is all in-patient.

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DR. LOBB: This includes in and out-patient.

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THE CHAIRMAN: Would you care to make





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Lobb 11802

an approximation of what it is now?

DR. LOBB: It would be very difficult.

THE CHAIRMAN: Supposing we said it was 50% either way?

DR. LOBB: I think that is reasonable.

THE CHAIRMAN: Dr. Van Wart thinks perhaps in-patient would be more than 50%.

DR. LOBB: I think it varies a great deal, depending on the Province and also the area in the Province.

THE CHAIRMAN: Are you able to speak at all for the Province of Manitoba where the out-patient service is being provided?

DR. LOBB: I cannot give you figures on it.

THE CHAIRMAN: That is the situation there, so I judge there would be a much greater volume of the X-ray diagnostic work being done by hospitals now than in the private clinics since it is being covered in Manitoba in the hospital and not in the private clinics.

DR. LOBB: I am sorry, I have not any figures on that, it is outside my particular field.

DR. BOUCHARD: In the Province of Quebec prior to the scheme coming in in 1960, the proportion of examinations done for hospital patients was 66%. We have not figures in terms of numbers of examinations, we have out of 18 units of professional work done by radiologists throughout the Province there were some 12,000,000 done for in-patients, so that figure could indicate a general trend, it could be spread across the



Lofb 11002

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DR. BOURGAREL: In the Province of

Quebec prior to the scheme coming in in 1954, the proportion of examinations done for hospital patients was 66%. We have not figures in terms of numbers of examinations, we have out of 18 units of professional work done by radiologists throughout the Province there were some 12,000,000 done for in-patients, so that figures could indicate a general trend, it could be spread across the





Bouchard 11803

country with reasonable accuracy.

DR. HOLMES: Could we draw your attention to the bottom of Page 9 where there is a brief description of the practice of diagnostic radiology. We have set down here at the top of Page 10 the percentage of examinations done by radiologists in private offices and it varies from Halifax which is zero percent to a high of 46% in Edmonton of the volume of diagnostic radiology done. Then it goes on to mention that this does not include X-ray examinations done by other medical practitioners other than specialists in radiology in their own offices.

THE CHAIRMAN: In the various clinics.

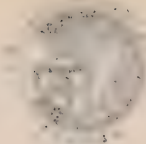
DR. LOBB: I can give you an exact figure for one province; in British Columbia in 1960, the total number of examinations was 371,140 and the total number of examinations in hospitals was 214,686.

THE CHAIRMAN: About the same as Quebec, so that is one of the practical problems is going to arise in trying to implement this recommendation whether you are going to move it out of where it is now being paid for from the public purse into an area where it will be paid for privately. The site of the equipment would still remain in the hospitals as it is now?

DR. SLOAN: Yes.

THE CHAIRMAN: And the radiologist would use that just as the surgeon uses the operating theatre. How would you see the methods of supplying radiology services to thinly-populated areas as you recommend in Paragraph 5?





DR. HOLLAND: Could we draw your

attention to the bottom of Page 3 where there is a brief

description of the practice of diagnostic radiology.

We have set down here at the top of Page 10 the percentages

of examinations done by radiologists in private offices

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would still remain in the hospital as it is now?

THE CHAIRMAN: And the radiologist would

be that just as the surgeon uses the operating theatre.

Now would you see the methods of supplying radiology

services to thinly-populated areas as you recommend in

Paragraph 2?



Sloan 11804

DR. SLOAN: As we have pointed out in the body of the brief under the section dealing with the practice of radiology, this service to the smaller hospitals in the more remote areas is presently carried out in two or three different forms, in some instances radiologists visit the more remote hospitals at regular intervals to carry out those examinations which require the personal attention of a radiologist. At the same time they undertake to maintain supervision over the work done in the department of the technical side of the examinations and usually under these circumstances report on all of the X-ray examinations that are done in the hospital. This is done by a combination of reporting while you are actually in attendance at the hospital and arranging to have the film that may be made in between your periodic visits sent to your office for reporting. The report is returned by mail or telephone or telegraph where there seems to be any urgency. A second type of service to outlying areas is provided through a mail service where the films made in the hospital are mailed at the appropriate intervals depending on the volume of work to the radiologist who reports on the films and returns them and reports by mail again, or telephone or telegraph where there seems to be any urgency in the case.

Thirdly, there is a service which is very largely selective in nature in which the doctor on the spot who must of necessity undertake some of these radiological consultations on his own will in select cases in his wisdom and definition refer these films to a



11004 Sloan

PR. SLOAN: As we have pointed out in

the body of the brief under the section dealing with the practice of radiology, this service to the smaller hospitals in the more remote areas is presently carried out in two or three different forms, in some instances radiologists visit the more remote hospitals at regular intervals to carry out those examinations which require the personal attention of a radiologist. At the same time they undertake to maintain supervision over the work done in the department of the technical side of the examinations and usually under these circumstances report on all of the X-ray examinations that are done in the hospital. This is done by a combination of reporting while you are actually in attendance at the hospital and arranging to have the film that may be made in between your periodic visits sent to your office for reporting. The report is returned by mail or telephone or telegraph where there seems to be any urgency. A second type of service to outlying areas is provided through a mail service where the films made in the hospital are mailed at the appropriate intervals depending on the volume of work to the radiologist who reports on the films and returns them and reports by mail again, or telephone or telegraph where there seems to be any urgency in the case.

Finally, there is a service which is very largely selective in nature in which the doctor on the spot who has of necessity undertake some of these pathological consultations on his own will in select cases in his wisdom and discretion refer these films to a





Sloan 11805

radiologist in the nearest community for his assistance and help with the report and diagnosis on the case.

THE CHAIRMAN: In Paragraph 6, the payment of a fee for each service performed supplies the most satisfactory means, etcetera, and is the most likely to ensure the highest possible quality of service. Why should the quality of service be affected by the manner of payment?

DR. HOLMES: I refer you to Page 15, Paragraph 50, and if I might just summarize this, I think this gives the explanation for that statement and recommendation. This Association believe that the adherence to the fee for service principle is more likely to result in the patient receiving the best quality of radiological service. Many radiological societies, including the Canadian Association of Radiologists, have for many years recognized that there is an optimum number of examinations or units of service which one radiologist can be expected to perform efficiently, above which the quality of medical care begins to deteriorate. When a fee for the professional component of each radiological examination is set aside, there is a direct correlation between the volume of work and the income available for the professional staff. Thus as the volume of work reaches and surpasses the ideal limit, there is automatically available sufficient funds to provide for additional radiologists. I think that explains the mechanism which we feel is most likely to ensure that a radiologist will not be over-burdened with an excessive work load to the detriment of the quality of the work he is attempting to do.





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and help with the report and diagnosis on the case.

THE CHAIRMAN: In Paragraph 2, the

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most satisfactory means, etcetera, and is the most likely

to ensure the highest possible quality of service. Why

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to perform efficiently, above which the quality of

medical care begins to deteriorate. When a fee for the

professional component of each radiological examination is

set aside, there is a direct correlation between the

volume of work and the income available for the professional

staff. Thus as the volume of work increases and expenses

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that explains the mechanism which we feel is most likely

to ensure that a radiologist will not be over-burdened

with an excessive work load to the detriment of the

quality of the work he is attempting to do.



Holmes 11806

THE CHAIRMAN: How does he become over-burdened in the other manner of payment?

DR. HOLMES: In practising radiology the volume of work during the past few years there has been an increase, we estimate, of about 10% per year compounded, and experience, I think, has shown that in these situations where this type of arrangement has traditionally applied as it does in about 90% of the situations across the country that the supply of people is remaining available to look after this growing load.

THE CHAIRMAN: These are all in hospital situations pretty well, are they not?

DR. SLOAN: Yes.

THE CHAIRMAN: And the issue is whether they are paid on a fee for service basis or a salary basis. Both of these situations will have the same number of examinations to make, the input to the hospital cannot be affected by the manner of payment. Do you think if it is on a fee for service basis that the radiologist is able to control the number of people he would examine in a given day?

DR. SLOAN: No, sir, on the fee for service basis, as we have suggested, what the radiologist is able to control because of the direct relationship between the departmental income to volume of work is the number of trained people who will be available to do the work. On the salary type it has been our experience that that institution operates strictly on a budget formula and so much money is allocated for professional services in the X-ray department.





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Sloan 11807

THE CHAIRMAN: To whom does that money go?

DR. SLOAN: It is paid as a salary to the radiologist, but when he finds his work increasing in the optimum amount that one man is physically capable of doing efficiently, it then becomes a matter of doing battle with his hospital administrator and his board and ultimately with whoever controls the hospital finances in the Province to try and get monies approved for additional help in the department.



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DR. SLOAN: It is paid as a salary  
to the pathologist, but when it comes to work increasing  
in the optimum amount that one can be physically capable  
of doing efficiently, it then becomes a matter of doing  
battle with his hospital administrator and his board and  
ultimately with the very course of the hospital, because in  
the province to try and get things removed from the hospital  
help in the department.



Sloan

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4 DR. SLOAN: Now, it is often very  
5 difficult on the salary sort of arrangement because  
6 you cannot hire half a man, so to speak, on a salary.  
7 Whereas, where funds are available to the professional  
8 staff on a fee-for-service basis, they can attain the  
9 help in such numbers and at such time as they need it  
10 by supplementing their full-time staff with part-time  
11 or essential help, and so on. This provides an elasti-  
12 city which, for reasons that I couldn't begin to explain,  
13 are just not present under the other type of arrangement.

14 THE CHAIRMAN: Will you have one radio-  
15 logist in the hospital; you are speaking of where he  
16 is part of - what you have been talking about, I  
17 assume, is where your radiologist is part of a group  
18 and he may be called upon some day to help out.

19 DR. BOUCHARD: That may not be quite  
20 true. A radiologist cannot rely on the medical man.

21 THE CHAIRMAN: No. Is this fee-for-  
22 service basis you are speaking of for the unit system?

23 DR. SLOAN: That is one method of  
24 achieving it, yes.

25 THE CHAIRMAN: And does it accomplish  
26 what you wish for it?

27 DR. BOUCHARD: Mr. Chairman, the unit  
28 system has been one method of establishing what we  
29 thought would be a logical factor of fees instead of  
30 having a rather empirical method of assessing the  
value of our professional service. It has been based  
on the average time taken for each type of and variety of  
medical act and, of course, in diagnostic radiology

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THE CHAIRMAN: Will you have one more

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assume, is where your radiologist is part of a group  
and he may be called upon some day to help out.  
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true. A radiologist cannot rely on the medical man.  
THE CHAIRMAN: No. Is this fee-for-  
service basis you are speaking of for the unit system?  
DR. SCHLES: That is, one would be

achieving it, yes.  
THE CHAIRMAN: And does it encompass  
what you wish for it?

DR. SCHLES: But Chairman, the unit  
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thought would be a logical factor in the method of  
having a rather empirical method of establishing the  
value of our professional services. It has been based  
on the average time taken for each type of service or  
method, and, of course, in diagnostic radiology,



Bouchard

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there is a variety and number of short and long ones so the unit system is one which determines the value, the fee and the amount of professional work involved in each medical act and then there may be a slight component to account for experience and seniority but this is a more difficult thing to assess.

It's largely established on the average time spent for each examination.

THE CHAIRMAN: To a layman, and there are quite a few laymen in the country, there are certain phases and my fellow Commissioners here may have entirely different views, as you may appreciate. There may be many phases of health service which can be performed most efficiently under fee-for-service basis, and there may be other areas of medical services or on health services which can be performed on a salary basis.

Now, we are not concerned about the adequacy of salary. Even in those areas there must be adequate salary and we can understand the complaint that the salary system has lagged behind others in quality of opportunity amongst the various specialties and that kind of thing, but provided you could have quality insofar as the income was concerned, whether it's salary basis or another, you still want the fee-for-service basis, do you?

DR. HOLMES: Mr. Chairman, I think it isn't that we want it. I think we are sincerely convinced that the method and technique will result in the radiologist being able to carry out the work to the







Holmes

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level and quality which he feels he must do and that while it is possible on a salary arrangement with some situations that level of quality could obtain, but experience would seem to show that there is a greater tendency for the radiologists who are in departments where they are paid on salary to have excessive workloads to the point where they often are unable to give the time and the attention to certain types of procedures that can be done in other hospitals where the supply of radiologists is adequate.

THE CHAIRMAN: I know, but couldn't you have an adequate supply of radiologists on the salary basis?

DR. HOLMES: It tends not to happen, sir.

THE CHAIRMAN: Therefore, on the fee-for-service basis to have this reserve for taking care of the excess load, you must belong to a group on whom you can call for assistance?

DR. SLOAN: That is right.

DR. BOUCHARD: Mr. Chairman, not necessarily so.

THE CHAIRMAN: In the community where you could call - if you have one radiologist in a city or community that has only one, and then we must see this in terms of all Canada, not only in Toronto; in Montreal; in Winnipeg or Vancouver.

DR. SLOAN: Sir, let me add to that particular situation what we know happens where the income is correlated to the volume of work done and that



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THE CHAIRMAN: Therefore, on the fee-for-service basis to have this reserve for taking care of the excess load, you were talking about when you can call for assistance?

MR. SCOTT: That is right.

DR. ROUSSEAU: Mr. Chairman, not neces-

THE CHAIRMAN: In the community where you could call - if you have one radiologist in a city or community that has only one, and then he must see this in terms of all Canada, not only in Toronto; in Montreal, in Winnipeg or Vancouver.

MR. SCOTT: Yes, let me add to that

particular situation that we know happens where the income is correlated to the volume of work done and that



Sloan

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3 is in very short order that one man arranges to find his  
4 own assistance and help by bringing in a radiologist  
5 from somewhere else.

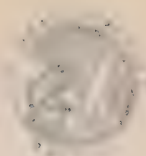
6 What we also know happens is that  
7 where that same man is on a salary and has to depend  
8 upon getting hospital administration and Board of  
9 Trustees' approval for the hiring of another radiologist,  
10 it's usually difficult to the point of impossibility  
11 to get him within time to relieve the situation.

12 THE CHAIRMAN: Thank you very much.  
13 I must say I like the way you discuss it. Your brief  
14 indicates that you think that there is a reasonably  
15 good supply of radiologists so that if the question  
16 is put: is there an actual shortage of radiologists  
17 to meet the situation that you have in mind here, that  
18 as the load goes up you are able to call on somebody?  
19 Is there someone to call on?

20 DR. HOLMES: Sir, I think that we  
21 have indicated that the supply is probably comparable  
22 to that in most other countries. However, I think if  
23 we can direct your attention to page 19 there is a  
24 table indicating the number of diagnostic radiologists  
25 who are certified each year and the totals.

26 Now, there seems to be an increase  
27 in the number of about 10% per year and we have stated  
28 that the increase in the volume of work seems to go up  
29 about the same. So we are just holding our own but  
30 superimposed on this is the fact that many of the  
procedures are becoming more and more complex and time-  
consuming and we are not complacent at all about the





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own assistance and help by bringing in a radiologist  
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as the load goes up you are able to call on somebody?  
Is there someone to call on?

DR. HOBBS: Sir, I think that we  
have indicated that the supply is probably comparable  
to that in most other countries. However, I think if  
we can direct your attention to page 18 there is a  
table indicating the number of diagnostic radiologists  
who are certified each year and the totals.

Now, there seems to be an increase  
in the number of about 100 per year and we have stated  
that the increase in the volume of work seems to go up  
about the same. So we are just holding our own but  
superimposed on this is the fact that many of the  
procedures are becoming more and more complex and time-  
consuming and we are not compensating at all about the



Holmes

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3 numbers that we have and that is why we are concerned  
4 that radiology will be in a position to compete with  
5 other specialties in recruits to train in radiology.

6 DR. BOUCHARD: May I add something  
7 to this? As far as radiation, therapeutic radiology,  
8 is concerned, there is a shortage. At the present  
9 time there are 67 full-time radiation therapists  
10 spending all their time in the treatment of cancer  
11 patients but to cover the field adequately we antici-  
12 pate that in the next five years we should be able to  
13 find approximately 20 to 25 more radiologists who will  
14 specialize in that branch of specialty. At the present  
time we don't know where they are going to come from.

15 THE CHAIRMAN: You have many competi-  
16 tors in the field for specialties. Now, you are  
17 affiliated with, or you are members of, the Canadian  
18 Medical Association, so I take it that on the general  
19 proposition or the submission we have had from the  
20 Canadian Medical and Provincial Medical Association  
21 that you are in agreement with the basic proposition  
there?

22 DR. HOLMES: That is right.

23 THE CHAIRMAN: In 9, you take up the  
24 cudgels on behalf of the career technicians. These  
25 career technicians - where do you find those? In  
hospitals and in the private radiology clinics?

26 DR. BOUCHARD: They are largely in  
27 hospitals, sir.

28 THE CHAIRMAN: Are there any employed  
29 where these x-ray clinics are?  
30



numbers that we have and that is why we are concerned  
that radiology will be in a position to compete with  
other specialties in recruits to train in radiology.  
DR. BUCHANAN: May I add something  
to this? As far as radiation, therapeutic radiology,  
is concerned, there is a shortage. At the present  
time there are 37 full-time radiation therapists  
spending all their time in the treatment of cancer  
patients but to cover the field adequately we antici-  
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DR. BUCHANAN: They are largely in  
THE CHAIRMAN: Are there any approved



Sloan

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DR. SLOAN: Yes, sir. We employ 18  
in our own offices.

THE CHAIRMAN: How do the salaries  
compare in the private practice and hospitals?

DR. SLOAN: Sir, I can only speak  
for our own locality at Vancouver and in that particular  
area we cannot compete on equal terms with the hospitals  
as to conditions of work and all the fringe benefits  
that go with hospital employment. The 5-day week;  
cumulative sick leave; pension plans and so on, and  
because we cannot compete on this level, we have to  
make it attractive to them by offering somewhat higher  
salaries in our private offices than generally obtain  
for a person of similar proficiency and similar training  
in the hospital.

Now, in the larger hospitals, with  
their large departments, probably the senior supervising  
technician is paid at a somewhat higher rate than  
anybody in the offices but then we do not have anyone  
of quite that seniority and responsibility but generally  
speaking we have to offer slightly higher pay to compen-  
sate for lack of fringe benefits and other attractions  
that the hospital can offer.

THE CHAIRMAN: I was just wondering  
what is the significance of No. 9 here, the establish-  
ment of a realistic salary scale.

DR. BOUCHARD: The main reason behind  
this is that we are a little disconcerted by the fact  
that we are pretty much like - deal with the nurses.  
The majority of radiological technicians are female





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THE CHAIRMAN: Now to the salaries

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technicians and naturally we have a tremendous turnover and I believe that it is a question on which some details could be easily obtained from the representatives of the C.S.R.T. and perhaps Miss Girard could also tell you more about it because it follows pretty much the same pattern as it does on nurses.

We have to start over and over again. We would like to be able to attract more male technicians that would look upon this as a career and their lifetime employment.

THE CHAIRMAN: Paying them on a different scale than the female technicians?

DR. BOUCHARD: It is difficult for equality of service sometimes to obtain better remuneration.

COMMISSIONER BALTZAN: Mr. Chairman, I do not think I can ask any questions after you got through being the Chairman of the Hospital Board. I think you have covered the territory completely. I think your answers have been excellent in relation to some things that were left hanging from previous presentations.

Could I just indulge for one minute and again repeat: you advocate the removal of diagnostic radiology from the hospital insurance scheme. I sort of read this thing into it. Tell me if I am right. What you actually advocate is the removal of diagnostic interpretations and reporting from the hospital insurance scheme. That is where your professional services come in.



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in.





Sloan

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DR. SLOAN: Yes, that is right.

THE CHAIRMAN: Not the technician.

DR. SLOAN: No.

COMMISSIONER BALTZAN: Or the machinery.

No further questions.

COMMISSIONER STRACHAN: Mr. Chairman, I may be on dangerous ground and I have no desire to supply some fodder for our friends, the press, as one brief related to this subject did the other day. I have no desire to get your pictures in the paper.

THE CHAIRMAN: We couldn't get a handsomer group.

COMMISSIONER STRACHAN: However, that is not my object. You appear to me to be a reasonably healthy looking group of men. Most of you well past adolescence. Maybe I would ask you this: is there any prevalence of ill effects of radiation on your own members or the personnel working in radiology?

DR. BOUCHARD: Mr. Chairman, the answer is no. There is a very adequate protection available for all radiation workers and by this I mean the radiologists, the radiological technicians and any other ancillary personnel working in our own department.

This has been achieved by several methods of control. First of all, electrically-speaking, all the equipment now is shock-proof. It is also ray-proof. Over and above taking the word of the manufacturer and being satisfied it has those qualities and affords that protection, we also carry, with the help of our radiation physicists, various tests and examinations to be sure this is so.





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THE CHAIRMAN: Now the technician.

DR. SLOAN: No.

COMMISSIONER KELLAN: On the machinery.

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Bouchard

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Then a most essential point as far as health is concerned, over and above an ordinary medical examination consisting largely of general physical, chest, lung, and examination of blood, we insist in all our hospitals, and also in private offices, we insist for the wearing of a film badge, which indicates the accumulation of any exposure during the period of a fortnight. This is sent to Ottawa, to the Health Services, and then if there is any exposure in the amount of what is considered by the International Commission of Protection as over what it should be, it is immediately reported, and action is taken accordingly.

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So there is a maximum amount of protection for the radiation workers and their families, and I might perhaps add that if the index of families is an indication that radiation workers are no longer sterilized by their own equipment, then the index of families among radiological technicians is quite good.

20

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DR. LOBB: There is one member of our Association who I last saw ten days ago. He has fourteen children and is going strong.

22

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COMMISSIONER STRACHAN: Then you have every confidence in the test badge available from Ottawa?

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DR. BOUCHARD: That is a routine procedure, yes, but as I say, over and above that we run periodic checks on all of the equipment, and also the protection facilities for each room, and we make sure that there is no radiation straying out of the room which might affect the patient.

29

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In this respect I think we are very



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3 well protected.

4 COMMISSIONER BALTZAN: How long have  
5 these people been wearing this radiation badge? What  
6 number of years?

7 DR. BOUCHARD: This is a service  
8 which has been existing now in Canada for I would say  
9 between ten and twelve years.

10 COMMISSIONER STRACHAN: May I go further,  
11 and ask you are you in a position to know anything of  
12 the existence of ill effects of radiation on the general  
13 public?

14 DR. BOUCHARD: Mr. Chairman, this is  
15 a very difficult question to answer, because records  
16 are simply not available to bring forward that degree  
17 of information. There has not been any survey made in  
18 that respect in Canada, but they have been made in the  
19 United States and in Great Britain and some Scandinavian  
20 countries, to try and determine factors of that nature.  
21 It is very difficult, and the radiologists group has  
22 been taken as one group, and some statistics have in-  
23 dicated that radiation workers, the incidence of leukemia,  
24 cancer of the blood, is about 5% higher, but this is  
25 not entirely on very firm ground. It is claimed that  
26 there is an increase of cancer in children. Well, in  
27 our own clinics, in our own province, I haven't seen  
28 any reflection of this, and we are having a registry of  
29 all cancer cases practically in every province, so that  
30 they are all recorded and scrutinized, and to the best  
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Bouchard

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4 DR. HOLMES: If I might go a little  
5 further. On page 2, as was read out, our Committee on  
6 Standard Units and Protection is preparing a plan to  
7 recommend registration of all sources of ionizing  
8 radiation in Canada, and a compulsory inspection pro-  
9 gram. There have been programs in the United States on  
10 a voluntary basis, and it has been shown generally that  
11 the equipment operated by specialists in radiology  
12 measures up to standard very considerably more than, as  
13 you might expect, someone who didn't have the added  
14 particular training, and Dr. Strachan, I am sure, is  
15 concerned with dental figures, and one survey in Oregon  
16 of 170 dental x-ray machines showed that only 22% of  
17 them met the standard of the coning down to delimit the  
18 beam, to have it going only in the direction that was  
19 considered necessary.

20 In other words, our Association feels  
21 that there is considerable room for improvement in the  
22 keeping track of the radiation that is being used in  
23 operating these various types of equipment, regardless  
24 of who operates them. CHAIRMAN: Those were the points.

25 COMMISSIONER STRACHAN: What year was  
26 that, Doctor?

27 DR. HOLMES: I couldn't quote you the  
28 year, sir, but this was in a fairly recent publication.  
29 We could get you that information, I am sure sir.

30 DR. WALTON: In my own province we have  
gone a little ahead of the Association of Radiologists,  
and we already have a full scale system for examining  
and measuring the output and the radiation fields around



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that, Doctor?

PR. HOLMES: I couldn't quote you the year, sir, but this was in a fairly recent publication. We could get you that information, I am sure sir.

PR. WALTON: In my own province we have gone a little ahead of the Association of Radiologists, and we already have a full scale system for examining and measuring the output and the radiation fields around





Walton

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4 all x-ray machines, whether by doctors, dentists,  
5 osteopaths, chiropractors, et cetera. These machines  
6 are examined at least once a year and sometimes twice a  
7 year, and in due course we anticipate legislation will  
8 be brought down on a provincial scale to cause the owner  
9 to follow the recommendations which are made up to him.

10 Up to now the voluntary co-operation  
11 has been extremely good. We found some very surprising  
12 and slightly worrying results during the course of this  
13 first survey, as one could imagine, but these have been  
14 cleared up.

15 DR. BOUCHARD: I would like personally  
16 to pay tribute to the Department of National Health and  
17 Welfare in Ottawa, which has really a very well developed  
18 system for radiation protection, and they are providing  
19 service and advice throughout Canada to the best of  
20 their ability, and that team has done tremendously well.

21 THE CHAIRMAN: And that covers the  
22 dental x-ray as well as the other?

23 DR. BOUCHARD: Yes.

24 THE CHAIRMAN: Those Oregon figures  
25 may not be relative to Canada, because this service,  
26 as in Manitoba where if you are moving forward in that  
27 direction now you may have a completely different  
28 situation from one year to the next?

29 DR. HOLMES: Yes.

30 DR. SLOAN : This is a very small scale  
example of the same situation, but in Vancouver  
approximately two years ago, in a building where there  
are approximately 60 dentists, and there were three





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general x-ray as well as the other?

MR. BOWMAN: Yes.

THE CHAIRMAN: Those Oregon figures

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Sloan

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4 medical officers that had various types of x-ray installa-  
5 tions, we called in the Provincial Research Council  
6 to do a very detailed survey of all the x-ray installa-  
7 tions in the building, both from the point of view of  
8 people in the offices and in the corridors, and waiting  
9 rooms outside the offices, and I think 55 dental units  
10 were surveyed, some of which had been in use for periods  
11 up to 20 years, and only two were found to be sufficiently  
12 defective as to shielding and coning as to require  
13 modification, and the others were quite well within the  
14 acceptance safety standards.

15  
16 THE CHAIRMAN: Thank you very much  
17 Dr. Gill.

18  
19 DR. GILL: We are certainly thankful  
20 to you, Mr. Chairman and to the Commissioners, who have  
21 given us the opportunity of presenting our brief. Merci  
22 beaucoup.

23  
24 THE SECRETARY: The next submission  
25 is from the Ontario Dietetic Association and will be  
26 exhibit number 340, and Miss Ketchen will introduce her  
27 group to the Commission.

28  
29 ---EXHIBIT NO. 340:

Submission of the Ontario  
Dietetic Association



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THE CHAIRMAN: Thank you very much

MR. GILL: We are certainly thankful to you, Mr. Chairman and to the Commissioners, who have given us the opportunity of presenting our paper. Merci

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Representation of the Ontario Dietetic Association

EXHIBIT NO. 340:



SUBMISSION OF  
THE ONTARIO DIETETIC ASSOCIATION

APPEARANCES: Miss M. Ketchen  
Mrs. H. Morningstar  
Dr. M. McCready  
Mrs. H. McKerchen  
Miss H. Goodrow  
Miss D. Tyers

MISS KETCHEN: It is an undeniable fact that proper nutrition is a basic and vital factor in promoting and maintaining good health of all people at every age level.

Although Canada has an ample supply of all the foods needed for adequate nutrition, the importance of proper selection of foods as a health factor is still too little known or appreciated. This lack of knowledge and appreciation is shared by the lay public and many of the professional people presently engaged in the fields of prevention and treatment of disease and in the promotion of better health. Many employers are unaware of the extent to which good nutrition can increase efficiency and cut down on absenteeism. Taxpayers do not realize that good eating habits, as a positive health factor, can reduce public expense for medical care. Government leaders should appreciate that poorly-fed people do not make good citizens so should develop sound nutrition policies and help to simulate a public awareness of their importance.

The dietetic profession believes unreservedly that nutrition should command greater





THE ONTARIO DIETETIC ASSOCIATION  
SUBMISSION OF

APPEARANCES:

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Ketchen

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4 attention in all phases of health work. Members of  
5 the National and Provincial Dietetic Associations are  
6 devoting their time, training and talents to the task  
7 of extending knowledge and stimulating interest in this  
8 vital science in a continuing effort to improve food  
9 habits of Canadians and lead to a higher level of general  
10 health.

11 On the basis of these convictions,  
12 The Ontario Dietetic Association respectfully submits  
13 the following observations and recommendations for  
14 consideration by the Commission:  
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McLaren

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On the basis of these convictions, The Ontario Dietetic Association respectfully submits the following observations and recommendations for consideration by the Commission:



Ketchen

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BL/dpw

We will turn to page 6, and I would like to read the recommendations, showing slides and the film as the exhibits.

On the basis of the above facts and observations, the Ontario Dietetic Association recommends -

(1) .... That public health departments at provincial, county and municipal levels secure the services of qualified nutritionists either as full-time staff members or as consultants who might serve several centres in one district;

(2) .... That the salary schedule recommended by the Ontario Dietetic Association in 1962 be adopted.

And I would like you particularly to look at page 1 of the Salary Survey Report which was put out this year by the Ontario Dietetic Association.

On page 5 there is a bar graph which shows the comparison of salaries paid to hospital dieticians compared with those in other professions. You will see that in the 33 dieticians receiving a salary between \$7,000 and \$10,000 only one is hospital; the dotted lines are hospital salaries. We would like to present that as an exhibit and also to call your attention to the salaries which the Ontario Dietetic Association is recommending.

We would also like, in connection with discussing hospital training, to mention again



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Ketchen

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the integrated internship which was represented to you by Dr. McLaren's brief.

The third recommendation is:

(3) .... That training programs for auxiliary dietary workers (food supervisors) be expanded.

I am sorry; in connection with hospitals, there were two slides we would like to show you.

(Shows slides)

I would also call your attention to the exhibit, the course for food supervisors. This course has been started by the Ontario Dietetic Association and the Ontario Hospital Association. I believe this course has already been mentioned to you before. There are 18 students starting this Fall in 1962.

The fourth recommendation is:

(4) .... That facilities and financing for additional training of homemakers by professional dietitians be provided.

We would like to show you slide 5.

This shows a typical homemaker who has been trained for this profession and goes in and takes charge of a family when the mother is in hospital or otherwise incapacitated. The next recommendation is:

(5) .... That more comprehensive courses in nutrition and foods be





Ketchen

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included in undergraduate and graduate studies of professional groups engaged in health service and allied fields.

There are no exhibits for that group.

The sixth recommendation is:

(6) ... That the possibility of forming a Co-ordinating Committee for Nutrition Research be explored;

(7) ... That more effective methods of communicating nutrition information be implemented.

We would like to consider the establishment of a consumer information centre. We would like now to show you a short film which will illustrate the kind of information which we feel should be available for homemakers.

(Shows film)





October

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/PM/hm

Ketchen

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MISS KETCHEN: There is one further recommendation and that is the need for the special attention to the nutrition and/or food practises of certain population groups be investigated and that programs designed to meet these needs be expanded.

We feel there are four groups. We have the group of nursing mothers and the school children and we have two slides taken from the Department of Education here in Toronto showing how school children are now being fed.

The second slide shows a teacher talking to the students about what they should have for an adequate meal. That is the end of the slides.

We would like to have programs designed to meet these needs.

COMMISSIONER GIRARD: Miss Ketchen, I believe your first recommendation was taken up in a different manner by another group this morning, by the Canadian Diabetic Association who were probably selling your product before you were here. They were very much in favour and recommended a diatetic consultant on a consultation basis for county health units or larger areas; does this tie up with what you are recommending?

MISS KETCHEN: Very much. The Ontario Dietetic Association has done a great deal of work with the Diabetic Association and we helped them with their book and are now editing a cook book for them.

COMMISSIONER GIRARD: Do you also have any dietitians in this type of position or is this something new?



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recommendation and that is the need for the special attention to the nutrition and/or food practices of certain population groups as investigated and that programs designed to meet these needs be expanded. We feel there are four groups, we have the group of nursing mothers and the school children and we have two slides taken from the Department of Education here in Toronto showing how school children are now being fed.

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COMMISSIONER GIBBARD: Do you also have

any dietitians in this type of position or is this some-

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Ketchen

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DR. McCREADY: I know the Canadian Diabetic Association has a very good person in this job, one, to my knowledge.

MISS KETCHEN: There is another one in Edmonoton now.

DR. McCREADY: They are doing, well, you cannot call it preventive work, it is really curative work they are doing.

COMMISSIONER GIRARD: It is specialized?

DR. McCREADY: Yes, I would like to see more of the same of the specialized people having an opportunity to work regularly on the health prevention and Department of Health just as the need is for more doing this kind of job with the Canadian Diabetics.

THE CHAIRMAN: Provincially or municipally or both?

DR. McCREADY: I think the figures we gave are staggering, 32 members of our profession are working in this type of government department and this is very sparse in a population of 18 million. We are graduating members that are needed and we realize that these members are suddenly striking out, I think the salaries have a good deal to do with it but I think as the people are wanted I think they will come. Up to date the Departments of Health have not thought perhaps of the very certain specialties, they go along with one in an area in a province and one is really overworked very greatly.

COMMISSIONER GIRARD: This person would be experienced though it would take a number of years





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Ketchen

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3 for this type of person, you would not be able to have  
4 them in large quantities.

5 DR. McCREADY: The worst of it is the  
6 best of these people are being trained for other  
7 developing countries, there is such a movement at the  
8 moment to have these people.

9 COMMISSIONER GIRARD: I was also  
10 interested in the training program for auxiliary dietary  
11 workers, food supervisors. This is the course that you  
12 mentioned is the six months course?

13 MISS KETCHEN: Six months and those  
14 people, I think of the 18 who are coming into the course  
15 following 1962, 13 of them are being sponsored by  
16 hospitals where they have been working.

17 COMMISSIONER GIRARD: Who pays this  
18 \$100.00 a month salary?

19 MISS KETCHEN: The Ontario Hospital  
20 Association pay \$100.00 a month from public health grants,  
21 that is where they are getting the money now but they  
22 are not at all sure they can keep on doing it.

23 COMMISSIONER GIRARD: Is the Ontario  
24 Hospital Association doing this as a pilot project?

25 MISS KETCHEN: Yes, we set up the course  
26 of study for them and it has worked very well. We would  
27 like to have this expanded in other cities in Ontario  
28 and other provinces have enquired about it.

29 COMMISSIONER GIRARD: You have not  
30 graduated any yet?

MISS KETCHEN: Yes, we have had two  
groups, the first was graduated this last year and there  
were 18 and there are 18 or 19 coming into the course in



Member

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Ketchen

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the Fall.

COMMISSIONER GIRARD: And they work under direct supervision of a dietitian?

MISS KETCHEN: Yes, they do the routine work and leave the dietitian and professional people free to organize and supervise.

COMMISSIONER GIRARD: It seems like a good arrangement in view of the shortage in hospitals.

DR. MCCREADY: I had a letter from a woman during the week, a woman dietitian, a trained person in Nova Scotia and they had tried this in their work to train the supervisors there in the vocational schools and they called the people dietary aids. She was explaining the difficulty was the salaries, they simply were not sufficient to attract good graduates of three years high school training and she was recommending that perhaps two or three years or even a shorter course for graduate XI or XII students might be the answer. She had met one very happy dietary assistant who was now getting \$300.00 a month. These people will have to realize there will be wonderful jobs for them but in the meantime perhaps we have not been paying them enough and the courses in the schools fail, chiefly because of lack of good positions. Would you not think this is improving?

MISS KETCHEN: I think this is improving but I think, first of all, if hospitals to get the hospital salaries for dietitians up and I think as a matter of fact the other people in the departments salaries will soon follow.







Ketchen

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4 COMMISSIONER GIRARD: I think it is  
5 the problem for lot of disciplines in the hospital.  
6 I was also interested in recommendation number 4 where  
7 you say that facilities and financing for additional  
8 training of homemakers by professional dietitians be  
9 provided. I did not understand this; do you mean by  
10 this that dietitians train homemakers or do they help  
11 other organizations to train homemakers?

12 MISS KETCHEN: We would like to feel  
13 that there are two groups. Dr. McCready, would you speak  
14 about the homemakers' service, the two groups.

15 DR. MCCREADY: I took a little part  
16 in this years ago myself and I would say that home  
17 economists or dietitians are certainly key people in the  
18 training, they certainly were in our training course  
19 years ago along with the social worker, the public health  
20 nurse, the medical mental health people and child  
21 development and family relations people so it was quite  
22 a composite training.

23 COMMISSIONER GIRARD: The homemakers  
24 have been in large demand by every profession that has  
25 anything to do with welfare of the family and you would  
26 feel that if homemakers were going to be trained in  
27 larger quantity that the home economist or dietitian  
28 or some of your group would be the proper place to have  
29 the facilities for the training of these people?

30 MISS KETCHEN: Yes, they should have  
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DR. MCCREADY: I came from lunch today  
at a training course of 40 women at our own college that



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COMMISSIONER GIRARD: The homemakers

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MISS KITCHEN: Yes, they should have

DR. MCCREEDY: I came from lunch today at a training course of 40 women at our own college that





McCready

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4 is being held at the College during the next few weeks  
5 or one week under Red Cross.

6 COMMISSIONER GIRARD: This helps me  
7 because so far I have not in my own mind known where the  
8 homemakers would be trained, what group would take on  
9 as a responsibility the training of homemakers. I think  
10 your group is really ---

11 DR. MCCREADY: May I add we had a group  
12 this past week in which they were hoping to establish  
13 the training in a high school in the hours after the  
14 regular school, perhaps from 4:30 to nine o'clock at  
15 night and get schedule 5 of the Federal Government paying  
16 their way to this course and really establish it as a  
17 program.

18 COMMISSIONER GIRARD: Who was going  
19 to establish it?

20 DR. MCCREADY: In the city high school  
21 in Ottawa the Board of Education and they threw this  
22 training course back on the social agency that was  
23 interested. They have a unique homemakers service in  
24 Ottawa available to all agencies and they were looking  
25 forward to doing their training in the future at the  
26 high school. This is something I think should be  
27 repeated with Boards of Education.

28 COMMISSIONER GIRARD: I think so. We  
29 need homemakers very badly in every part of the country.

30 THE CHAIRMAN: Thank you very much  
Miss Ketchen and ladies, we enjoyed the presentation,  
the exhibit and the pictures.

MISS KETCHEN: Thank you.







Ketchen

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4 COMMISSIONER BALTZAN: May I add it  
5 was most appetizing.

6 MISS KETCHEN: We do appreciate the  
7 opportunity of presenting this brief. Thank you.

8 THE SECRETARY: The next submission  
9 is that of the Canadian Society of Radiological Technicians  
10 and it will be known as exhibit number 341.

11 ---EXHIBIT NO. 341:

Submission of the Canadian  
Society of Radiological  
Technicians.

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COMMISSIONER BATHMAN: May I add is

MISS KETUMEN: We do appreciate the

opportunity of presenting this paper. Thank you.

THE SECRETARY: The next submission

is that of the Canadian Society of Radiological Technicians  
and it will be known as exhibit number 301.

From action of the Canadian  
Society of Radiological  
Technicians

EXHIBIT NO. 301:

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SUBMISSION OF  
THE CANADIAN SOCIETY OF RADIOLOGICAL TECHNICIANS

APPEARANCES: Miss M. J. Martin  
Mr. G.A. Wilkinson  
Miss A.N. Plowman  
Mr. I.R. Fisher

MR. WILKINSON: Mr. Chairman and Members of the Commission, I would like to first of all introduce the members of this Society who are in support of me. On my right is Miss Mary Jane Martin, Vice-President of our Society; on my immediate left is Miss A.N. Plowman, Secretary of our Joint Council on Technical Training and on my far left Mr. Robert Fisher, Past President of our Society.

May I say that in view of the fact that the Canadian Association of Radiologists have preceded us this afternoon that I will not lay any bearing on the type of work that involves the radiological technician but will immediately proceed to the recommendations which we have made starting at page 5. These are based on the original concepts of the society in that we are predominantly an educational group. The first recommendation is that the under-graduate training of radiological technicians be maintained at the presently required standards, unless, until such time as conditions permit the improvement of these standards.

It is important to point out to the Commission that this factor of a reduction of standards possibly exists and we wish to make sure these standards are maintained and possibly improved. The reason for





STUDY OF

Miss M. J. L. L. L.  
Miss A. A. A. A.  
Miss A. A. A. A.

APPENDIX B

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On my right is Miss Mary Jane Martin, Vice-President of  
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Wilkinson

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4 this are stated on the following page and I will not  
5 take the time to go through them.

6 The second recommendation is that  
7 it is recommended that the present under-graduate training  
8 of radiological technicians be improved as soon as  
9 possible by the establishment of central training  
10 schools throughout Canada. This has been started in  
11 some provinces and we are in agreement with this pro-  
12 cedure providing the standards of training are kept up  
13 to those as recognized by the joint council on technical  
14 training.

15 Recommendation number three is that  
16 facilities be made available for the post-graduate training  
17 of radiological technicians to provide a source of  
18 fully trained and qualified teachers of radiological  
19 technique. This will go along with the centralized  
20 training under institutions of flexibility where we feel  
21 it will be necessary to maintain a source of fully  
22 qualified teachers by providing the ability for those  
23 people to be trained fully prior to being inserted in  
24 this field.

25 Recommendation number four is that a  
26 recruitment program be instituted to attract more long  
27 term employees to the field of radiological technique.  
28 Under this recommendation it refers to the necessity of  
29 increasing the number of male radiological technicians  
30 in the society. It is felt, in spite of the fact I am  
flanked on both sides by females who have done very much  
for the profession and there are many females who have,  
that the predominance of female technicians in the field





Wilkinson

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4 is leading to a large turnover which makes it difficult  
5 to maintain standards.

6 Recommendation number five is that  
7 personnel practising the science and art of radiological  
8 technique be under the supervision and control of a  
9 radiologist, a specialist certified by the Royal College  
10 of Physicians and Surgeons or by the College of Physicians  
11 and Surgeons of the province wherein such personnel may  
12 practise.

13 It was pointed out by the radiologists  
14 that this is important and we feel it is important too  
15 because of our combined knowledge and the effective  
16 factor on radiation both on personnel and patients  
17 involved.

18 The conclusions drawn from these  
19 recommendations are self explanatory and we do not have  
20 anything further to say to you at the moment and we  
21 welcome any questions you may have.  
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/MR/ss

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4 THE CHAIRMAN: Thank you, Mr.  
5 Wilkinson. I was wondering if, having heard the dis-  
6 cussion that preceded the one before the last of the  
7 radiologists, if you had any general observations to make  
8 arising out of some of the questions or some of the  
9 discussions that took place which involved your organiza-  
tion, necessarily involved in your organization?

10 MR. WILKINSON: There was a question,  
11 if I recall correctly, wherein you were questioning the  
12 number of long-term personnel which they made reference  
to in their brief.

13 We also have made a non-specific  
14 reference to the high percentage of less than five-year  
15 graduates who exist within the Society, and it was a  
16 very happy situation that yesterday morning our new  
17 register for 1962 reached my hands and I was able to do  
18 a quick survey from the register and find out that 62%  
19 of the total membership was graduates of less than five  
20 years' standing which means that the relative turnover  
21 rate is quite high. The actual percentage of male tech-  
22 nicians, the total is only 22% and drops as low, in my  
23 own Province of Quebec, to 10% of the overall number of  
technicians.

24 THE CHAIRMAN: Have you any figures on  
25 the return to the profession? I understand this initial  
26 loss is perhaps primarily due to the fact that the recent  
27 graduate gets married. Probably the greatest do return  
28 to the profession. It's something where a girl who is  
29 trained, gets married and then eventually returns, as we  
30 have heard in the nursing profession where that situation





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is quite extensive and accounts for a great percentage of the practising nurses of today.

MR. WILKINSON: You are referring to the fact that they get married and do not cease nursing, or cease being technicians but remain in the field after they are married?

THE CHAIRMAN: Return to the field some years after marriage. The family starts to grow up.

MR. WILKINSON: We do have incidents of this nature. I would not say that it is high. Basically if one goes through our non-active list that we keep in our Society wherein someone may keep in touch with the Society and the techniques, without being an active member. We have about 361 people who are non-active. Their basic function there, I believe, is that they wish to keep in touch with the field in the event that there is a possibility that they might, for some reason or another, have to return to the field.

THE CHAIRMAN: What about part-time work? Is there anything of that kind?

MR. WILKINSON: They can do part-time work, yes, under the non-active status.

THE CHAIRMAN: Are they being called upon? Is there any program by which they are called?

MR. WILKINSON: No, sir, no specific program. It is possible if they are available for work that they could be called upon for work, but there is no specific program to utilize people of this nature.

THE CHAIRMAN: I think Miss Girard would probably explain it further. In the nursing profession







Wilkinson 11838

that has been pretty well developed.

COMMISSIONER GIRARD: If I might, Mr. Chairman, I would like to get some information on something basic to these courses. I don't think we know too much about these courses for radiological technicians because in my hospital there is a school of training, but I do not feel I know too much about it.

The schools are provided by the hospitals and the money for the training of radiological technicians so far now is part of the hospital budget. Is that right?

MR. WILKINSON: That is correct, yes.

COMMISSIONER GIRARD: And the teaching is done by the radiological staff?

MR. WILKINSON: That is right, both radiologists and senior radiological technicians.

COMMISSIONER GIRARD: And the courses are taken in the hospital with a certain amount being charged as a token salary or some amount is provided the student?

MR. WILKINSON: This varies from institution to institution and from Province to Province, Miss Girard. In some particular provinces bursaries are provided for students, in others they are not.

There is no basic scale across Canada for students as far as any provision for salary is concerned. Generally speaking I would think that the average amount that would be paid the student over a two-year training period would be something in the nature of \$100.00 a month as average. I know in Ontario it is the





Wilkinson 11839

setup that exists now.

COMMISSIONER GIRARD: Is there a standard curriculum?

MR. WILKINSON: There is a standard curriculum both in the therapy field and the diagnostic field.

COMMISSIONER GIRARD: And who is responsible for the standards of these schools?

MR. WILKINSON: The standards of the joint council on technical training through the C.M.A. is set up for the approval of training schools across Canada; standardizing the type of training that is given in the institution, and in addition to that, we also have, of course, our examining board which handles individual requirements of the students applying to these schools.

COMMISSIONER GIRARD: This is the type of training that is in existence?

MR. WILKINSON: That is right.

COMMISSIONER GIRARD: You recommend that this be kept in existence until such time as you are able to get something on a higher plane or a higher standard?

MR. WILKINSON: Well, this statement is made on the basis, and I think that my colleagues will agree with me, with the increasing amount of work in radiological departments wherein the people who are required to do the teaching are also required to look after departmental affairs, makes it increasingly difficult to maintain a high standard of training.

As a consequence, I think it is generally felt that one must look to the future to a more





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Wilkinson 11840

centralized type of training wherein the most adequately trained personnel are available in a central point to make use of this high training factor to train technicians rather than distribute them over hospitals, shall we say, throughout the Provinces.

COMMISSIONER GIRARD: Where would you locate this central centre? Would this be in a University? In a technical college? What was your thinking along this line?

MR. WILKINSON: Well, insofar as the technical schools are concerned at the moment that are starting out both in British Columbia and Alberta, these are being run under the Department of Education, I believe. Institutions of technology wherein the X-ray technicians are being included in this program.

We feel that there is also beyond this point the necessity of college education for those at the teaching level.

We have instituted within our own Society, as is pointed out in the brief, what we call a fellowship series of lectures which is designed to provide a fellowship for those technicians who are making a career of it. Becoming senior technicians to provide this teaching pool from which the education factor might come.

COMMISSIONER GIRARD: Now, we come to where I came in. I wanted all this for my benefit, because it was never clear to me, how these schools function.

I think one of your problems is there is a large turnover. We call it in nursing a mortality rate among nurses. They really don't die. They are as



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Mr. McKinnon

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good as dead to us for some years. I think when I interjected you were talking about the possibility of these people coming back to work after a certain number of years and we in nursing couldn't do without the married nurses these days. In some organizations they are as high as 50 and 60% of the staff.

Are you able to have this type of arrangement with your technicians? Do they come back to work some time after they have left?

MR. WILKINSON: This does happen, but when the Chairman spoke of this in reference to an organized program, no. I know of no organized program that is based on the fact that married technicians will be attracted back on this basis.

You do find girls that get married and leave for several months and will reapply after they more or less get settled and these stay on staff for a while. It doesn't necessarily mean they get lost, but generally speaking, it means that they have a short-term employment.

COMMISSIONER GIRARD: I think what the Chairman was speaking about, it comes to me now, would be that we have a refresher course for nurses that have been away from the profession for a long time. Since things change so fast, they cannot be absorbed again in the profession without going through a certain type of refresher course and because we have this, I think a lot of nurses that have been away, married nurses and nurses that have not nursed for a long time, they feel a lot better about coming back to nurse if they know they can go





11341 Wilkinson

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Wilkinson 11842

through this type of course. Be rehabilitated to a certain extent in nursing.

MR. WILKINSON: Is this refresher course done at the individual hospital level?

COMMISSIONER GIRARD: Yes. In fact, the nurse that has been away from the profession that has not been registered for five years must take this refresher course before getting her registration back. At least in our Province, in the Province of Quebec this is two or three months. This is in a hospital and this person will get her registration when the Director of Nursing certifies to the Association that this nurse has completed this refresher course and that she is ready to take on the regular nursing load.

MR. WILKINSON: Well, this would be more or less done at departmental levels within the field of radiology where someone who had been away from the department for a certain period would have to have a certain period of indoctrination into the change of procedures.

There is no specific program of that nature.

COMMISSIONER GIRARD: I think the Chairman was also referring to another question that has come up a few minutes ago when we were talking to the radiologists about the male students and how you would go about attracting them.

MR. WILKINSON: How we would go about attracting the male students? Well, as you have perhaps gone through many months now this all boils down to the



11842 Williamson

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COMMISSIONER: Yes. In fact,

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MR. WILLIAMS: Well, this would be

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MR. WILLIAMS: Now we would go about attracting the role students? Well, as you have perhaps gone through many months now this all boils down to the





Wilkinson 11843

question of finances really, and its basic theory. However, I do not agree completely with the factor of finances.

I think this has to offer someone sufficient incentive not only from the point of finances, but from the point of interest in a field, to provide continued interest so that it does not become something static, and there is no longer any interest in the field.

I think radiology as a technical group, paramedical group can offer this interest, but basically it boils down, as I have said, to the financial factors.

Some years ago when I first entered into this field, I was advised against it by a vocational psychologist who said I was entering a girls' field. This seems to be a common concept that people generally have created in their minds from going to these mass TB surveys where they stand up in front of machines and just go through in a long row. They do not think there is anything to the actual practice of the radiological technique. However, as one gets into it one appreciates there is some difference, considerable difference.

COMMISSIONER GIRARD: Thank you very much.

COMMISSIONER VAN WART: Is there much shortage in your profession on employment?

MR. WILKINSON: Much shortage on employment? This varies across the country, Dr. Van Wart. In this particular area of the country, here in Toronto and in Western Ontario, I would say that there wasn't any



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shortage in your profession or employment?

Yes, definitely. Much shortage in

employment? This varies across the country, Dr. Van Wert. In this particular area of the country, here in Toronto and in Western Ontario, I would say that there isn't any



Wilkinson 11844

particular shortage. Although I think that people would agree with me that if it were not for the factor of British-trained technicians from outside the country, or Australia, and so on, coming in to relieve factors which would be shortages, that we might be in a serious condition in some places.

COMMISSIONER VAN WART: Have you any figures, percentage of the shortage in Canada?

MR. WILKINSON: No, I have not, sir, on that.

COMMISSIONER VAN WART: Would it be as high as 17%?

MR. WILKINSON: As high as 17%? Could be in some areas, yes.

COMMISSIONER VAN WART: Thank you.

MR. WILKINSON: This will vary from area to area in the country.

COMMISSIONER BALTZAN: Just one question. Are your members sufficiently attracted to go out to small hospitals to take charge of an X-ray unit and have these readings done by somebody, either visiting or have the X-ray plates forwarded elsewhere for reading? Do you find your membership are attracted to small hospitals or have you difficulty in placing members in small hospitals?

MR. WILKINSON: I think it would be a matter of degree there, Dr. Baltzan, as to how small a hospital you are referring to.

The concept seems to be that in rural areas where there is insufficient work of one nature for





Wilkinson 11845

a qualified person to do, that they have sort of multiple qualifications wherein they can do haemotology, any tupe of other lab work that would be required of lab technologists, in addition to doing X-ray work. The general trend, up until today, has been that people are not happy staying in the rural areas because basically they come in to the larger urban areas to train and they get urbanized, if I may use that phrase, and they do not want to go back to the country.

We feel this could be countermanded to some extent by an increased male recruitment program, plus the fact that possibly there should be more not major centres, but subsidiary centres in the rural areas to which technicians could go, would be attracted to go to work in this area and provide health services for the people in that particular area.

The standards that presently exist in many of the rural areas we find deplorable, but, quite frankly, we have not reached an answer.

COMMISSIONER BALTZAN: In a 50, 60 bed hospital frequently three or four physicians, at least there is quite a volume of work but not enough to engage a radiologist, especially in view of the shortages. Would a unit like that be attractive?







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MR. WILKINSON: A 50 or 60-bed hospital in relation to its ratio of out-patients and in-patients -- if the out-patients were of sufficient volume to give them a full day's work, yes, it could, but I rather doubt that in a rural area that this might be the case.

COMMISSIONER BALTZAN: I have in mind such places. That is the reason I asked that question.

MR. WILKINSON: Our basic concept of the overall technicians and the profession of radiological services with regard to the centralized schools is that these centralized schools will provide the basic theory aspect of the training. We cannot supplant in the schools of technology the school of hard knocks that one learns in practice. This factor must continue if one wants to be a radiological technician.

COMMISSIONER BALTZAN: My question was about people who are competent, able and willing.

MR. WILKINSON: Well, there is a possibility, but as I say there has to be an incentive factor there for the person to go.

THE CHAIRMAN: Well, Mr. Wilkinson, thank you very much for your submission and your attendance.

MR. WILKINSON: May I say thank you very much, sir, for the courtesy of allowing us to make this presentation and discussion.

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THE CHAIRMAN: Well, Mr. Wilkinson,

thank you very much for your statement and your answer.

MR. WILKINSON: Now I say thank you

very much, sir, for the courtesy of allowing us to

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THE SECRETARY: Mr. Chairman, the next submission is that of the Ontario Society of Radiological Technicians. It will be Exhibit No. 342 and Mr. J.S. Flanagan will present his group.

--- EXHIBIT NO. 342: Submission of the Ontario Society of Radiological Technicians.

SUBMISSION OF THE ONTARIO SOCIETY OF  
RADIOLOGICAL TECHNICIANS

Appearances: Mr. J.S. Flanagan  
Mrs. M.F. Cameron  
Miss M.J. Martin  
Mr. N.E. Lidkie

MR. FLANAGAN: Mr. Chairman and members of the Commission: this may seem like the third strike of the afternoon. We have already had two attempts at impressing on the Commission the aims, objects and desires of the people concerned with radiology.

I did feel, however, that our presentation is somewhat different. We have aimed it at specific requirements in the Province of Ontario. We have made recommendations which we feel are applicable to the needs of Ontario. In some of these instances they may be equally applicable to the rest of Canada, but we would not like to come out and say they should be used universally.

The brief that has been presented, the initial pages of introduction and historical background I do not intend to read, except to point out that the Ontario Society of Radiological Technicians was the first Society of technical staff employed in







Flanagan

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radiology founded in Canada. I should not say the first. It is the only one still in existence. There was an earlier one formed in Canada as a branch of the American Society of Radiological Technicians. It was formed in 1935, so it has had 27 years of progress. In relation to this progress I have a graph which I would like to present to the Commission as an exhibit and which I will refer to later.



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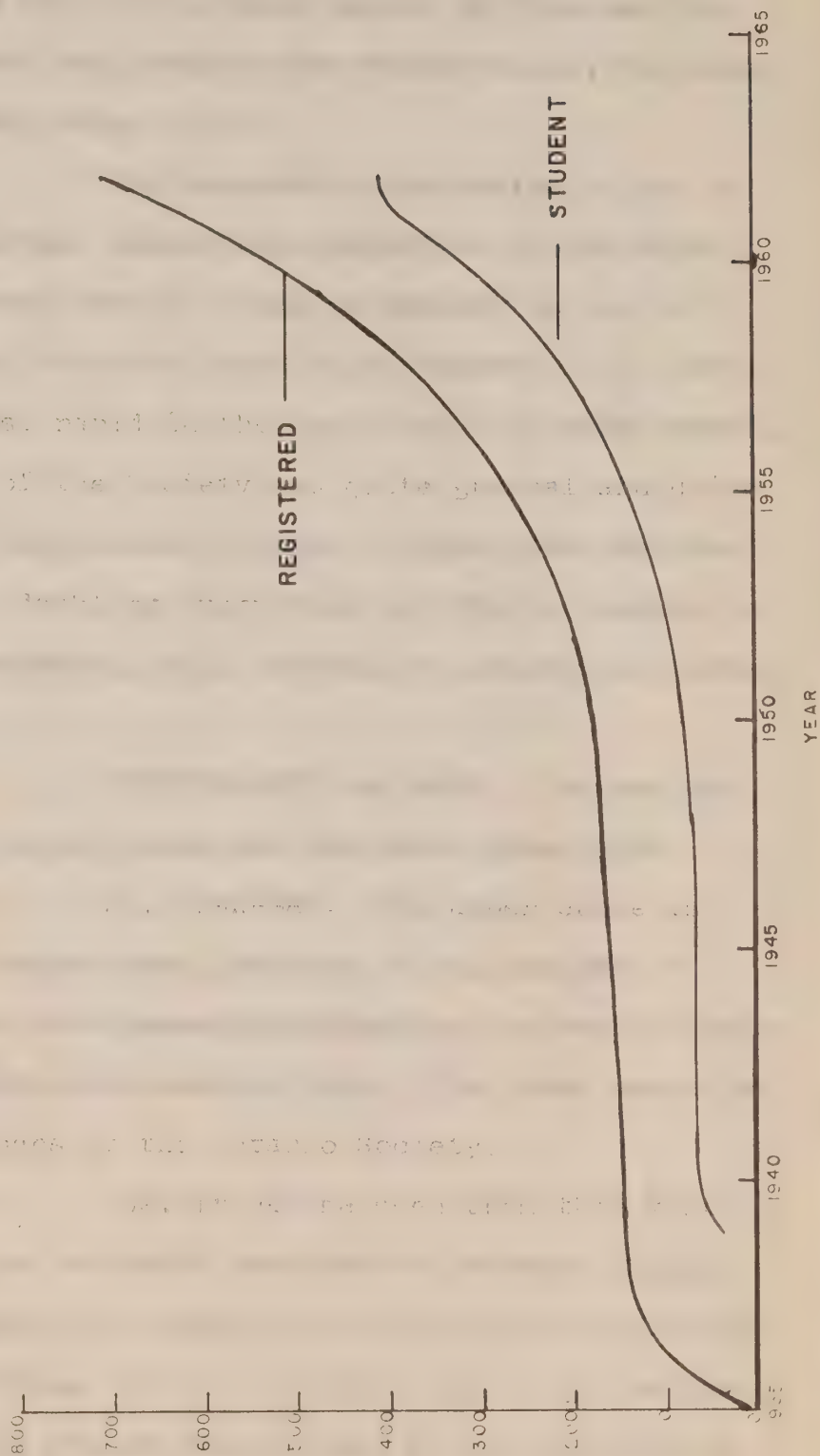
ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Flanagan

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# ONTARIO SOCIETY OF RADIOLOGICAL TECHNICIANS

## MEMBERSHIP







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We were largely instrumental in having a Canadian Society of Radiological Technicians formed, and one of the prime movers of this was Mrs. M.F. Cameron, who, despite her tender years, has been in this field since 1935.

The membership statistics - you will find the current membership statistics in the brief and this graph that I intend to present to you will give you an indication that this progress in 27 years has been most rapid in the last five. In other words, the growth of the Society was quite gradual and quite small until approximately 1958. Since 1958, we have been almost doubling every year and the indication is that our membership will continue to expand at a great rate.

COMMISSIONER VAN WART: Can you tell me what the upper curve and the lower curve are?

MR. FLANAGAN: The upper curve is registered technicians, members of our Society in Ontario that have passed the Canadian Society of Radiological Technicians examinations. The lower curve is student members of the Ontario Society.

Now, it can be seen from this graph that while the students continue to increase equally with the registered technicians, they are now falling off, not falling off, but are levelling off. We don't see, with the present facilities, we can continue to increase the number of students we can take into our profession.

THE CHAIRMAN: 228 at the moment?



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Flanagan

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THE CHAIRMAN: 198 at the moment?



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COMMISSIONER VAN WART: Is the upper curve reaching saturation now? By that I mean ---

MR. FLANAGAN: We don't have, by any means, all x-ray technicians in Ontario as registered technicians.

COMMISSIONER VAN WART: No, but I mean, have you reached the stage where you do not desire many more radiological technicians?

MR. FLANAGAN: No, sir.

THE CHAIRMAN: There is employment for more?

MR. FLANAGAN: There is employment for more, as was indicated in the brief of the radiologists. It is expanding at the rate of at least 10% per year, so there will be a demand for at least an additional 10% of additional technicians every year and we do not foresee that there is going to be a point that there are too many technicians, due to the fact that the student enrolment is levelling off.

COMMISSIONER VAN WART: Have you any figures on your percentage of shortage now? Would it be 17%?

MR. FLANAGAN: I don't think so, not in Ontario.

COMMISSIONER VAN WART: Would it be 10%?

MRS. CAMERON: I could place 15 technicians today in Ontario if I had to.

MR. FLANAGAN: This is percentage-wise, out of approximately 600. On page 11 of our brief we







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2  
3 have set out the problems to be resolved. These  
4 problems are actually not different than you have  
5 heard from the other members of the C.S.R.T., and  
6 from the Canadian Association of Radiologists. We  
7 have the problem of training facilities, probably the  
8 biggest. The problem of staff losses, and in terms  
9 of what Miss Girard has stated to be mortality, we  
10 have called wastage of staff. We have this, of course.

11 The problem of additional male students  
12 and the needs of post-graduate training. We have also  
13 covered the problem of staff in small hospitals, and  
14 I don't intend to read these sections of our brief.

15 I would like to start on page 15, with  
16 the recommendations.

17 A. To Improve Facilities for Basic Training

18 It is recommended that Federal-Provin-  
19 cial grants be made available to selected hospitals to  
20 assist them in providing physical space, and the  
21 specialized equipment necessary to establish at least  
22 five, and possibly six Regional Training Schools for  
23 Diagnostic Radiological Technicians. (A list of  
24 possible locations is attached as Appendix 11)

25 These schools should be equipped with  
26 special apparatus, such as Anatomy Teaching Models,  
27 Model X-Ray Units, and other demonstration equipment  
28 for the teaching of Physics and Electricity, and the  
29 production of X-Rays.

30 The initial selection of centres  
eligible for these grants could be made with the assis-  
tance of the Joint Council on Technical Training,

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Canadian Association of Radiologists - Canadian Society of Radiological Technicians, based on needs as indicated by past examination results. Final approval as to the sites would be sought from the Committee on Technicians' Affairs, Section of Radiology, Ontario Medical Association - Ontario Society of Radiological Technicians.

The size of grants needed would probably be in the amount of \$5,000.00 to \$10,000.00 per centre. This might be budgeted to be available for no more than two centres a year, so that experience could be gained in the setting up of these centres, rather than having a mushroom development.

The Ontario Hospital Services Commission might also participate in helping to set up these organized Training Schools. Such a School would require the employment of instructors, and provided the School is situated within a hospital, it is considered probable that the Ontario Hospital Services Commission would provide for the salary costs of these instructors.

B. To Facilitate Post-Graduate Training

It is recommended that Bursaries and Subsistence Grants be made available as Health Education Grants to promote post-graduate training of Ontario Radiological Technicians. These might be made in three categories as follows:

(1) Junior Registered Technicians' Subsistence Grants:

Grants to provide subsistence only, and to be available to Junior Registered Technicians, who desire to spend periods of one to three months in the larger Teaching Centres in Ontario, to become



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B. To Establish a Radiology Centre Training  
It is recommended that Universities and  
Colleges should be made available as Health Education  
Grants to promote post-graduate training of Ontario  
Radiological Technicians. These might be made in  
three categories as follows.

Grants to provide stipends only,  
and to be available to Junior Radiology Technicians,  
to be able to spend a minimum of one to three months in  
the larger teaching centres in Ontario, to become



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familiar with Specialized Radiographic Techniques,  
so that these applicants may be qualified for further  
opportunities.

Three grants per year, up to a maximum  
of \$600.00 might be given, each to be available upon  
the supply of full information from, and the recommen-  
dation of the Ontario Society of Radiological Techni-  
cians. It is suggested that these grants be given  
directly to technicians applying through the Society,  
and that the awards be made on the recommendation of  
the Board of Directors.

Maximum Total: \$1,800.00 per year.

(11) Hospital Bursaries:

Bursaries given to cover travel,  
salary and subsistence, and to enable Ontario hospitals  
to send graduate Technicians to any Canadian or  
American Teaching Centres of Radiological Technique,  
to gain further knowledge of Training and Teaching  
Methods, so that these Technicians may improve the  
instruction in their own hospitals.

Two bursaries per year might be given,  
up to a maximum of \$1,000.00 each, to be available and  
given to hospitals which make application for same,  
to subsidize further training and experience for  
Technical Staff. This bursary to be awarded on the  
recommendation of the Ontario Hospital Association,  
to hospitals which provide evidence that they are  
desirous of improving or setting up training.

Maximum Total: \$2,000.00 per year.





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(111) Bursaries for Senior Registered Technicians:

Bursaries to cover travel and subsistence to enable Senior Technicians to attend post-graduate courses held by the Canadian Society of Radiological Technicians in various parts of Canada. These bursaries would help to assure a sufficient number of qualified, Canadian-trained Chief Technicians.

Four bursaries per year might be given, up to a maximum of \$300.00 each, to be available upon the recommendation of the Ontario Society of Radiological Technicians, as approved by the Board of Directors.

Maximum Total: \$1,200.00 per year.

Maximum Total of all bursaries and grants: \$5,000.00 per year.

We would like to state that the Committees and Organizations named above have not been consulted with regard to these recommendations, but have been named as the Group or Organization logically concerned in each instance.

The Ontario Society of Radiological Technicians would, at any time, consider it a privilege to submit further clarification of the recommendations made, and to offer comments and suggestions pertaining to the training of Radiological Technicians within the Province of Ontario.

In conclusion, we would like to express our misapprehensions about an all-embracing, fully Nationalized Health Scheme. We believe that it is obvious that the National Health Service in Great Britain has been responsible for a marked shortage of





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concerned in such matters.

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trained Technicians in Britain. The causes of this are largely economic, as Technicians' salaries have been "frozen" to help keep down the costs which increased so rapidly with the demands for medical services. This has resulted in a great loss of Technicians, who were obliged to seek employment in Industry or Commerce, or to emigrate to countries where their profession is more rewarding.

In December, 1961, 242 vacancies were listed in the Journal of the British Society of Radiographers, which constitutes a 17% shortage in radiological Technical Staff. Many articles have been written in this Journal, and in British newspapers such as, "The Times", and "The Journal", deploring the shortage, and urging that steps be taken to remedy it. (Selections from these articles may be found in Appendix 11). The serious shortage of Technicians, in some areas, has resulted in the emergence of firms of contractors, who pay Technicians more than the rigid National Health Service salary scale, and then hire them back to the distressed hospitals at greatly inflated rates.

The Ontario Society of Radiological Technicians submits that our suggestions regarding the setting up of adequate Central Training Schools will provide the necessary number of qualified Technicians for the hospitals of Ontario, but that these Technicians will only remain in the hospitals if the standards of employment and opportunities for advancement are competitive with those in other fields outside the hospitals. Post-graduate education, according to our recommendations



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would provide a supply of highly skilled Technicians, who will, in the future need to be obtained within Canada, since the influx of Technicians from Great Britain, which has eased the situation here, undoubtedly will not continue. It should be pointed out as well, that excessive lowering of the standards here would result in large numbers of Technicians accepting employment in the United States, which could easily result in a sudden and drastic shortage in this country.

It has been submitted that the Royal Commission, in studying the provision of adequate health service in Canada, should inquire into: "How much responsibility may safely be removed from the people, consistent with the maintenance of democratic freedom?" This statement was given to you by Dr. M.J. Lynch at your preliminary hearings in Ottawa. We would respectfully submit that inquiry should also be made into: "How much freedom may safely be removed from Medical and Para-Medical personnel, consistent with the maintenance of adequate health service?"





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THE CHAIRMAN: Thank you, Mr. Flanagan.  
You appear to have, you say, covered the field pretty well.

Now, you heard the discussion we had first with the radiologists and then your Canadian Association. Have you any observations to make on the questions, subjects that were then discussed?

MR. FLANAGAN: I would say the most important part that was brought out in the previous briefs was the reference to career technicians. We would like to emphasize the necessity for this. We find that it is probably the biggest problem, that we train people only to lose them in six months to one year after they have received their proper training, and we have quoted in our brief that 25 to 35% of our students leave us.

THE CHAIRMAN: Having said that -- you are in the field -- what can be done about it? You can't keep them from getting married, and it wouldn't be desirable that we try. But is there another situation? You should recruit them from another age group, for instance; you should be doing something else about it instead of just lamenting.

MR. FLANAGAN: Mrs. Cameron has also come up with the figure of approximately 18% that might come back to us in later years. This is certainly much lower than the figure in nursing.

THE CHAIRMAN: But it is still a substantial figure.

MR. FLANAGAN: So we don't lose all of



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4 them permanently. But the only real solution is more  
5 male technicians being recruited. The percentage of  
6 male technicians to female technicians we have given in  
7 our brief is roughly 17%, and I think this would have  
8 to be raised in order to overcome this problem. And  
9 Mr. Wilkinson I think pointed out that this is largely  
economic.

10 COMMISSIONER VAN WART: Could a system  
11 of increased increments and salaries be an inducement  
12 for male technicians into the field?

13 MR. FLANAGAN: I wonder if Mr. Lidkie  
14 could answer this, because he is chairman of our committee  
on salaries and working conditions.

15 MR. LIDKIE: Well, I would say, sir,  
16 there is now generally in most of the hospitals a system  
17 of increments. The problem I think that exists is that  
18 the increments don't necessarily keep in line with the  
19 increments that are generally paid in industry, and  
20 consequently male technicians, who perhaps have been in  
21 the field for three or four years, find that their future  
22 may not be quite as promising as they originally thought  
23 and consequently they leave the field for some other  
enticing employment.

24 COMMISSIONER VAN WART: But he does  
25 not know what his increment may be a few years hence?

26 MR. LIDKIE: No, not entirely, because  
27 I think in the last few years there has been a decided  
28 increase in the general increments that have been given  
29 in hospital work because I am sure they now understand  
30 they are now competing with industry and they have to



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4 increase these increments and so the situation is better  
5 than it has been, and we would hope it would continue  
6 to be better. I would say that the person entering  
7 radiology at this stage certainly could look forward to  
8 a better financial return than one, say, entering four  
9 or five years ago. I think perhaps if that was stressed  
10 now it might entice more male technicians to enter the  
11 field at this time.

12 We do not have any established increments  
13 in that we are still at the mercy of each individual  
14 hospital what they are going to give as at the end of  
15 the year. Perhaps some form of definite increments, if  
16 it was known and published, would be an asset in this  
17 particular instance.

18 THE CHAIRMAN: What are your basic  
19 educational requirements?

20 MR. LIDKIE: The basic educational  
21 requirement is Grade XII education with four options.

22 COMMISSIONER VAN WART: You mentioned  
23 in your brief about the service in England, the cause  
24 of the shortage was simply a monetary one and the  
25 technicians are coming out to Canada and other parts of  
26 the Commonwealth as the result of that.

27 THE CHAIRMAN: Because of the frozen  
28 position.

29 COMMISSIONER VAN WART: The frozen  
30 position. That is why I am wondering if a system of  
increments would not tend to offset such a system in  
Canada here.

MR. FLANAGAN: Our Society have prepared



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MR. LUCKY: The basic educational requirement is Grade XII education with four options. in your brief about the service in England, the cause of the shortage was simply a monetary one and the technicians are coming out to Canada and other parts of the Commonwealth as the result of that.

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4 a recommended salary schedule which is circulated to  
5 all hospital administrators. This schedule is not  
6 maintained in all respects, but we feel that hospitals  
7 are accepting it. One hospital may not accept our  
8 salary scale in one category and another hospital may  
9 give the starting salary but their senior technicians  
may be underpaid.

10 COMMISSIONER VAN WART: How do your  
11 salaries compare with other provinces in Canada?

12 MR. LIDKIE: I do not have any definite  
13 figures on this. There again I think it depends a lot  
14 on locale where it is difficult to get a technician to  
15 go to some out-post hospital or some northerly district.  
16 They are enticed by a little higher salary than they  
17 might get in, say, Toronto or the immediate area. I  
18 would assume that this situation probably exists across  
19 Canada where an area that isn't too highly populated  
find they have to pay a little higher salary than an area  
that is populated.

20 COMMISSIONER VAN WART: Do you find  
21 that technicians are coming from other parts of Canada  
22 to Ontario?

23 MR. LIDKIE: Yes. I don't know that  
24 I would class it as an influx; I haven't personal  
25 knowledge of any great trend towards it. I imagine there  
26 is some. In the last few years it has been a question  
27 of the number of technicians coming from Great Britain  
28 rather than changing so much from various provinces in  
Canada.

29 THE CHAIRMAN: Have you noticed that  
30 the technicians that you have trained in Ontario are





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THE CHAIRMAN: As you noticed that the technicians that you have trained in Ontario are



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4 leaving Ontario for other parts of Canada?

5 MR. FLANAGAN: I think Mrs. Cameron  
6 could answer this.

7 MRS. CAMERON: We have a great many  
8 applications from the Maritimes, also from British  
9 Columbia. In Canada most of our applications come from  
10 those two provinces. Occasionally we have had perhaps  
11 half a dozen transfers from Saskatchewan within a year.  
12 The greatest exit of our Ontario technicians is,  
13 unfortunately, to the U.S.A. and our students seem to  
14 be attracted by the mecca of the U.S.A. But I am pleased  
15 to say that quite a few come back, quite a few return.

16 THE CHAIRMAN: Mr. Flanagan, thank you.  
17 We appear to have covered the subject of radiological  
18 technicians and we are certainly much better informed  
19 than we were earlier in the afternoon. We are very  
20 grateful for the trouble you went to in your brief and  
21 for your presentation.

22 MR. FLANAGAN: Thank you, sir.  
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MR. FLANAGAN: Thank you, sir.



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THE SECRETARY: The next submission, Mr. Chairman, is from Dr. Goodwin. It is a private submission, to be known as exhibit 343.

---EXHIBIT NO. 343:

Submission of Dr. N.L. Goodwin.

SUBMISSION OF

DR. N. L. GOODWIN

APPEARANCE: Dr. N.L. Goodwin

DR. GOODWIN: Mr. Chairman, the general tenor of the brief can be outlined in the preamble, which I will read, if I may.

At the present time there is an adequate amount of medical and hospital care available for all those who know how to go about obtaining it. The primary responsibility of the Federal Government is the improvement of the general economy of the Federation so that the private citizen has the income sufficient to purchase health services in the future. Although health services are specifically not the responsibility of the Federal Government, health services can be directly affected by Federal as well as Provincial action by enacting legislation which will indirectly render existing personnel and facilities more available and which will prevent many indispositions which now require health services.

I divide the brief up into four parts:

(a) Improvement of availability of existing services;





THE SECRETARY: The next submission,

Mr. Chairman, is from Dr. Goodwin. It is a private submission, to be known as exhibit 348.

Submission of Dr. N.L.

SUBMISSION OF  
DR. N. L. GOODWIN

Dr. N.L. Goodwin

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I divide the brief up into four parts:  
(a) Improvement of availability of existing services;



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4 (b) The prevention of the indispositions which cause  
5 the use of these services that would not occur  
6 if these things didn't occur in the first place;  
7 (c) Then some suggested legislation which is possible;  
8 and  
9 (d) Also an outline of a prepaid plan if it became  
10 necessary to introduce one.  
11 Without increasing the number of  
12 personnel and facilities now available for health service,  
13 a greater number of Canadians would receive better  
14 medical care if all Federal Departments abandoned the  
15 medical field except for the armed services on active  
16 duty overseas, thereby permitting personnel now in  
17 Federal service to enter private practice. People now  
18 receiving health service from Federal Agencies could  
19 then receive them privately. That is to say, within the  
20 geographical confines of Canada, the medical services  
21 of the Federal Departments employee, army, R.C.M.P., and  
22 could be available from the local doctor. The Federal  
23 Government would have enough problem of its own if it  
24 looked after the medical care of the Canadians in  
25 Palestine, the Canadians in the Arctic and the Canadians  
26 in the ships at sea. In Palestine family life is not  
27 allowed, in the Arctic it is not allowed and at sea it  
28 is not allowed, and I believe the Federal Government  
29 should pay attention to having an equal complement of  
30 male and female population in these areas and leave all  
the medical care in the organized provinces to the  
local physician.

- (b) The prevention of the indispositions which cause the use of these services that would not occur if these things didn't occur in the first place;
- (c) Then some suggested legislation which is possible
- (d) Also an outline of a prepaid plan if it became necessary to introduce one.

Without increasing the number of personnel and facilities now available for health services a greater number of Canadians would receive better medical care if all Federal Departments abandoned the medical field except for the armed services on active duty overseas, thereby permitting personnel now in Federal service to enter private practice. People now receiving health service from Federal Agencies could then receive their private care. That is to say, within the geographical confines of Canada, the medical services could be available from the local doctor. The Federal Government would have enough problem of its own if it looked after the medical care of the Canadians in Palestine, the Canadians in the Arctic and the Canadians in the ships at sea. In Palestine family law is not allowed, in the Arctic it is not allowed and at sea it is not allowed, and I believe the Federal Government should pay attention to having an equal complement of male and female population in these areas and leave all the medical care in the organized provinces to the





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4 Federal legislation to extend territorial  
5 waters, we are working on that I know, and it will come  
6 about in due course to improve the quality and the merit  
7 of our trade and commerce actions which are now going  
8 on. Parliament should spend its time doing that sort of  
9 thing rather than meddling in Provincial matters and  
10 fiscal matters, the Federal Government has absolute  
11 control over fiscal matters. You will note in China  
12 there are very few fish go up the Yangtse River to the  
13 Pacific and you are probably aware that the Pacific Ocean  
14 is larger than all the continents put together and this  
15 land was formed with fish that returned up the rivers  
16 where it could be trapped instead of being over-fished  
17 and having their fingerlings and fry killed by large dams  
18 on the way down to the water. Which is a federal matter  
19 which will improve the health of the people.

20  
21 Number three, duplication of health  
22 services can be reduced by the closing of all out-patient  
23 departments in hospitals, and the granting of hospital  
24 admission privileges to physicians who are willing to  
25 undertake in the first instance the treatment of all  
26 medical conditions, and who are willing to be responsible  
27 for the complete course of treatment of a patient once  
28 the patient is accepted for treatment.

29  
30 There is some concern that the mere  
fact that the out-patient department is taken to the whole  
world outside of Canada that their medical situation is  
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THE CHAIRMAN: You do not suggest the  
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1867

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out-patient department originated in Canada?



Goodwin 11866

DR. GOODWIN: I certainly did not. However, there is a feeling, I believe, that out-patient departments are necessary for the teaching of medical students and so on. I think this feeling is there because the people now in this field honestly believe it is necessary but really the reason they do is because their fathers had the system and their fathers had the system, and their grand-fathers had the system. There is very little concrete thinking on this, and when the professor is in his private office where he is allowed to take private patients, he is not down in the out-patient department with the interne without instruction whereas this is a duplication service and the nurse or the radiologist, the dietitian is duplicated. If the professor is teaching in his own private office, it would be just as good, if not better than an out-patient department system of teaching.

The other half of three is concerned with the continuous care of the patient from the original illness right through until the end of the illness, which is the concern of some of the professors now that they want to take the student out to follow a patient along at home. One of the cries that we hear, and I gather the doctors on the Commission hear, is that "Doctor, when I call my doctor on the phone or try to get a doctor to come to see my boy, nobody comes". I think the complaint is there because they do not have a doctor who they know, who knows them, that is, more or less their doctor and the doctor has them as his patient. Very often when a patient goes to hospital he loses contact with his family

Goodwin 11222

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Goodwin 11867

doctor in the hospital and three or four doctors look after the same patient. If a patient gets a rash they have to call in a dermatologist and the right hand does not know what the left hand is doing and the patient is discharged and nobody knows what happened in the hospital during the six or seven days. The general tenor of my remarks is that if five doctors were reduced to one, there would be far more doctors in practice to take care of the public.

Number four: The physicians would indirectly become more available for working longer hours as a physician if income tax deductions were allowed for the cost of employing handymen to perform domestic duties physicians now perform in and around their own homes.

This comes to mind because we know that there are several physicians who do their own domestic work because if they hire someone they have to pay them and they have to work longer hours in order to pay the handyman. In other words, these physicians would spend more time with patients if they were able to take their wall building and bricklaying and domestic painting expenses from their income tax.

Additional positions would also become available for direct health services if no deductions were allowed in computing taxable income for gifts to voluntary health associations. There are many, many, many, many, many voluntary organizations that employ doctors and if these employees to these associations were not represented as income tax deductions these do-good associations would not be able to employ these doctors and





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Goodwin 11868

they would have to go to work practising medicine.

An increase in the number of practitioners and health services could be indirectly increased in sparsely populated areas by the assignment of those duties to private practitioners that are now assigned to full-time non-practising provincial and federal government employees.

Specifically, the doctors that are employed by the federal government to look after the native Americans on the reservations where there is a place as a reservation to support one doctor, if everyone went to one doctor. Also, in some provinces there are public health doctors in rural areas travelling around from year to year costing money that properly could be distributed amongst the practical doctors in this area which is a way to get doctors in outlying areas without direct subsidy or giving them work they can do.

Next, I would speak about prevention. An increased number of physicians and health services available for the public will be made possible if automobile accidents were prevented. The Canadian culture is aware of many methods to prevent illnesses such as those caused by automobile accidents. Our culture knows how to construct one-way streets, how to manufacture safer automobiles, how to separate pedestrians from automobiles on the same street, and how to train automobile drivers as well as aeroplane pilots. It is the duty of the legislatures to reduce injuries from accidents. As, for instance, if the streets going North and South were fourteen feet higher than those going East and West, you

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Goodwin 11869

would never have these accidents, except at level crossings.

Injury by house-fires can be completely eliminated by the construction only of fireproof houses that are heated without combustion. The cause of house-fires is because the houses are combustible and we know better than this, we can build houses that are fire-proof.

The reduction of accidental food-poisoning can be indirectly affected by firm legislative action. Breast-feeding should be encouraged, the consumption of naturally occurring foods rather than processed foods could be taught and the pollution of water and air should be prevented.

The culture of the people of the Canadian Federation is such that it can afford to permit only those business practices which will eliminate many of the dangers of living, and the electorates should insist on specific remedies such as the elimination of over-head electrical wiring. This is only a matter of cost, we know how to do it, put it underground.

Then I come to suggested legislation: The direct or indirect payment of medical and hospital care by the employers of the Armed Services and the RCMP by the guardians of native Americans by the Provincial Welfare Departments for the medically indigent.

Federal Armed Services and veterans' hospitals should be turned over to governing bodies composed of private citizens.

You are quite aware from your figures





Goodwin 11889

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Goodwin 11870

that the length of stay in veterans' hospitals is longer than in general hospitals or other non-profit hospitals. There is more continuation of care in a private hospital whereas in a veterans' hospital they are looked at by Dr. A and sent to Dr. B, looked after by Dr. B and sent home and the left hand does not know what the right hand did. It is not necessary but some of the veterans' hospitals in Canada are closed to admissions on weekends.

Financial support of hospitals should be withdrawn for hospitals operating out-patient clinics or for admitting on their medical staff physicians who abandon patients as soon as the physician's interest in the patient elapses.

Allowing physicians in private medical practice who are ready, willing and able to respond to the calls of their regular patients, to deduct the expenses of employing their own gardeners, painters and handymen.

Employing private practitioners to perform part-time public health, Army and Coroner's duties and releasing of almost all public health physicians from full-time posts.

It is somewhere in the neighbourhood of 3,500 doctors, I believe, and your records will probably show that.

The granting of building permits and building loans only for fireproof dwellings which are on land areas large enough to permit home recreation facilities. One is keeping the people in back garden on the busy weekends when the roads are crowded and having by-laws requiring the house being built up against the



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Goodwin 11871

road, so the waste space between the road and the garage is not lost, because it is just for decoration purposes.

Not allowing as a recoverable hospital cost in any prepaid hospital plan the expense of the bottle-feeding of new-born.

As you can see, if the mother chooses not to breast-feed her child, but chooses to put the hospital to the expense of bottle-feeding with all the dangers of life that are encountered, she could have this providing she pays for it.





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Goodwin

11872

COMMISSIONER STRACHAN: Is this always a matter of choice, by the way?

DR. GOODWIN: Doctor, I do think that except the cases of prematures, where the mother has T.B., or some disease it is the doctor's order, of course, but in other cases it's pressure put on the doctor by the family and even the hospitals which enforce the doctor's order, or at least encourage them to order breast-feeding because of the medical audits and so on, what-have-you, but as soon as the mother gets home the baby is fed by bottle.

That is all right. That puts the responsibility of putting salt in the milk on the mother, not on the aide or the ward aide or maid who fills the bottle from the stockroom and general stores. It's an unnecessary cost. It's a dangerous cost. I think if the doctor has his own way he would have breast-feeding preferably.

Item D is a prepaid health service plan.

If it becomes politic to introduce compulsory Provincial Health Plans it might be wise to have a \$250.00 deductible clause permissible for those people who produce a certificate from a co-operative, bank, or a trust company stating that such person is undoubtedly financially responsible to pay medical bills of at least \$250.00.

I think the schedule of fees shows very few operations because of amount of money, medical fees really don't hurt as hospital bills do. In



11872

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Goodwin

11873

summary, in my brief, I have, Mr. Chairman, asked for no more money to be spent.

I do not believe any more money has to come from the Federal Treasury or the Provincial Treasury to improve health care. I believe the facilities and the personnel in all areas are presently here, if adequately used. Enough buildings, enough doctors, enough dieticians, radiographers, etc., except nurses.

The only shortage that I believe in Canada is the student nurses who are training in the hospitals with the in-service 36-month course.

COMMISSIONER STRACHAN: Does that apply to dental personnel?

DR. GOODWIN: I think there is sufficient amount of dental personnel if preventive care was inaugurated by legislation, not probably for orthodonture.

THE CHAIRMAN: Are you practising now, Doctor?

DR. GOODWIN: No, I am not practising at the present time. I am not practising law or medicine.

THE CHAIRMAN: Well you certainly have many novel ideas here. The mere fact that you think there is plenty of everything is the most novel one of the lot because everybody else has cried about the deficiencies.

DR. GOODWIN: I think, Your Lordship, that those people had an axe to grind personally. A lot has to do with the education of the public. What





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Goodwin

11874

they demand, and so on.

THE CHAIRMAN: The fact that you came and put these ideas before us is very salutary. It is the essence of inquiry of this kind that we should hear not only from those who have orthodox views but those who have unorthodox views and your views, I think, must necessarily come in that category this afternoon insofar as the general trend is concerned.

We are obliged to you for having accepted the invitation and for having submitted the brief and for your explanation as you proceeded which, of course, obviated the necessity of questioning because you made the thing self-explanatory as you went along.

We are grateful to you and thank you for the submission.

We will now rise until 9.30 tomorrow morning.

--- Adjournment.



11874 Goodwin

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